Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 00001Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 0733M NDERSON 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mandrin Hospice House Harwood Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 24, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 🗷 F Months Days Hours Min Yrs 1913 374-09-1990 Canada Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Anne Arundel 1 ☐ Yes 2X No MD Annapolis 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 21401 96 Market Street USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: 3 ₩ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) "IInk" Charles Fox 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 96 Market Street Annapolis, MD 21401 Garry L. Anderson, son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 1/2/09 Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Rd. Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Waste disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 mont Month Year Day 5 ☐ Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 ☐ No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? HOSPICE Other: 4 \sum Nursing Home 5 \sum Residence 1∐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) Housi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Division of Vital Records, P.O. Box 68760,

requires that the death certificate be executed burial-trans and the attending physician thed for use as the burial þ signed t peen has page 2 s Hospital or Attending Physician: The certificate this After death. 124 hours after death.

le Funeral Director; A pletely filled in by the fu

Physician

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Examiner

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28a-f

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e filed within 72 hours after de al Hygiene. other than "natural", or item

Department of Health and Mental Hygien Important: If Item 27 is marked other the any illury or other traumatic security on one

Physician

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Baltimore, Maryland 21215-0036

event, the Medical Examiner must be notified

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the within To the

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(Check only

29b. Signature and title of certifie

Name and address of per

6 ☐ Could not be

Year)

determined

pleted cause of death (Item 23a) (Type, P 32. Degistrar's Signatur

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 21:20 PM Robert Bartlett Adams 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Agnes Baltimore Hospital N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours 1 M 2 F Yrs. 82 Director 214-22-6854 MAY 6 1926 New Jersey Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show od other than "natural", or items 23a or 28a-f shov event, the Modical Examinar must be notified at Catonsville 1 □Yes 2 No Director Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane, HR-T-15 21228 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married Married 1 Yes 2 No 21215-0036 If Yes, Give Year or Dates: 1942-45 1 ☐Yes 2 No Specify. þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, the Media once. Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Superintendent Construction Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Adams Nellie Irene Bartlett Ethel Benjamin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21228 Velma C. Adams - wife 719 Maiden Choice Lane, HR-T-15, Catonsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 01/05/2009 Baltimore, MD 21. Signature of Funeral Street, ense H. Williams 2MacNabbodFuneral Home, P.A. - Hull 301 Frederick Road, Catonsville, MD 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Prostate concer Physician Metastatic years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examine radiation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a 1 □Yes 2 □No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? nonsmall cell lung Comcel 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown phods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 ☐ Yes 2 🗷 No 1 ☐ Yes 22 or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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Registrar
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31. Date filed (Month, Day, Year)

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Ave,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S.

Registrar's Signature

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Bultimore, MD. 21229

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year feldt 12:05AM Irainia 03 2009 4a. Facility Name (I not institution, give treet and number) 4b. City, Town, or Location of Death 4c. County of Death Columbia Howard Howard County General Hospital If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days 1 M 2 F Min 219-12-9720 86 Nov 2, 1922 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No **Ellicott City** Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10504 Baltimore National Pike 21042 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 □Yes 2 No Specify White Specify: 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesperson Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sterling Ezra Blacksten Lula Mae Yingling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joan D. Stump 10502 Baltimore National Pike Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan 08, 2009 **Pipe Creek Cemetery** Uniontown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Distribution the dise are shock, or heart failur. Approximate Interval Between Onset and Death e. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. SEPTICEMIA Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): UTI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events acceptable of the conditions of the conditio REMAL FAILURE resulting in death) Last Due to (or as a consequence of): DEMENTIA IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othany injury or other traumatic event

Director

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Maryland

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Medical

State Registrar

spital or Attending Physician: The law requires that the death certificate be executed ours after death.

Leral Director: After this certificate has been signed by the attending physician and filled in by the funered director, page 2 should be detached for use as the burial-transit P.O. Records, of Vital Division To the Hospital o within 24 hours aft To the Funeral Di

an/Medical Examiner

23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No 27. Manner of Death 1 Accident

3 🗌 Suicide

5 ☐ Pending investigation

6 ☐ Could not be

determined

Date of Injury (Month, Day, Year)

and manner stated

1 patient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

1 ☐ Yes

28d. Describe how injury occurred 2 🗆 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

29b. Signature and title of certifie

PHYSICIAM

0062704

Suite 100

30. Name and address of per 3290

on who completed cause of death (Item 23a) (Type, Print)

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien2009Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 4 40 PM **Physician** Year RUTH ADAMS ZODY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BATIMORE TOWSON MO NURSING HONE CROMWEU If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth NOV 30. 1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1□ M 3/7/F MaryTand 232-26-1298 87 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1X Yes 2 No Director Baltimore Maryland None 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 21239 USA 1551 Burnwood Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: <u>م</u> 3 ☐ Widowed 4 X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence William Adams Florence Ruth McCurdy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald F. LeSieur Friend 1551 Burnwood Road Baltimore, Maryland 21239 20a. Method of Disposition
1 Disposition
2 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State Loudon Park Cemetery Jan 6, 2009 Baltimore, Maryland 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 22. Name and Address of FaciliMitchell-Wiedefeld Funeral Home Inc gnature of Funeral Softice Licensee 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Carple ec disease or condition resulting in death) Due to (or as a consequence of): who me S. pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy in the past 12 mor Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specity) 9 Unknown 9 ☐ Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1√No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

P.O. Division or Vital Records,

Examiner sician and burial-transit attending physician for use as the buria the death certificate be been signed by the should be detached has

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

/Medical

3altimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

State Registrar

DHMH 17 Rev 1/2001

FEDUNAVAO 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Lesda

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TEN MOSO

32. Registrar's Signature

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29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH 9887 1/12/09 JH State of Maryland / Department of Health and Mental Hygiene 2009 00005 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** Year 1:300 M SARAH JANE BAUMAN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner If Under 1 Year (State or Foreign **Funeral** Security Number -24-9455 (In yrs. last birthday) Date of Birth (Month, Day, Year) Hours 1 ☐ M 2**X** F Months Days Min Yrs. Director PA APRIL 19.1922 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. 1 TyPYes 2 □ No MD N/A Directo BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3907 ORLEANS ST Funeral 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: à 1 □Yes 2 → No Specify: 3 XWidowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOME HEALTH CARE GIVER SUNSHINE SERVICES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM IRA NUNAMAKER ၉ IDA MAE BUCKLEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RAYMOND MCGEE-SON 2418 ORLEANS ST BALTIMORE, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ATLANTIC CREMATORY 1/7/09 4 ☐ Donation 5 ☐ Other (Specify) GLEN BURNIE, MD 22. Name and Address of Facility CHARLES S. ZEILER AND SON, INC 21. Signature of Funeral Service Licensee 6224 EASTERN AVE BALTIMORE, MD 21224 art 1. Pinter the liseage, on heart fail are Lis complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or as a consequence of): attending physician and for use as the burial-trar Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 DaNo 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year n signed by the a Id be detached for 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has but director, page 2 sh Be Certification: To this

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, nours after death.

neral Director: After this
filled in by the funeral di within 24 hours a

Baltimore,

		24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?	26. Place of Deal	th (Check only one)
1 Yes 2 X No	Hospital: 1 inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing He	ome 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	m (Month, Day, Year) Injury Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not to determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best of my knowledge, death occurred at the time, date and place milner: On the basis of examination and/or investigation, in my opinion, death occur milner.	, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

(Check only one)

29c. License number 29d. Date signed (Month, Day, Year)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9,000 Franklin

State Registrar

Medical

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2009 Ran /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Balto Longreen 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days 1 M 2 YF Mary 1936 219-38-3741 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 Tes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21213 Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🌠 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ZNO Specify. Specify: Dack ۾ 3 Widowed 4 Divorced 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Eoce. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) urse's 12 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Casson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Son 20b. Place of Disposition (Name cemetery, crematory or oth 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final YEARS HTHERO 9CL CARDION ASCULAR disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Munknown 1 🗌 Yes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Box 68760,

Division or Vital Records, P.O.

A and the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi physician a the burial certificate has i

Be 25. Was case referred to medical

2 No 1□ Yes 26. Place of Death (Check only one)

examiner?		Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatient	3□ D	OA Other: 4	Nursing H	ome 5 Residence 6 Other (Specify)
27. Manner of Death 1 Natural 2 Accident	5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes		28d. Describe how injury occurred
3 ☐ Suicide 6 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At h building, etc. (Special	ome, farm, stree	t, factor	ry, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

Medical Certification: To

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

us ACE 32 Registrar's Signature 31. Date filed (Month, Day, Year) JAN 0 6 2009

KICBRIDERD BATIMORE, MI) 21236

within 24 hours after death

To the Funeral Director:
completely filled in by the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:30 A M January 1, 2009 Melvin Burkins /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil Port Deposit 501 Craigtown Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 1**⋈**M 2□F Maryland 64 25, 1944 Director 213-42-3845 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show ad at 10a State 10b. County r 28a-f sh notified a 1 ☐ Yes 2 No Directo Port Deposit Maryland Cecil 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code pe pe filed within 72 hours after death with 21904 USA "natural", or items 23a 501 Craigtown Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Carpet Sales the 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil ment of Health and Mental H tant: If item 27 Is marked oth Be <u>Violet S. Hankins</u> Charles M. Burkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 Craigtown Road, Port Deposit, MD 21904 permit. Pages 1 and Department of Health Important: If item 27 any injury or other troonce. Beth Burkins/ Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 1-3-09 Hillton Service Corp. Towson, Maryland 21. Synuture of Funeral Service Acensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ire. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final Lung Cancer Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed nding physician and use as the burial-tra Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director; / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 26f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours after within 24 hours a To the Funeral C To the Hospital

Ö σ, or Vital Records, Division

State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

Maria Carrillo

29b. Signature and title of certifier

29a. Certifier

(Check only

Medical



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

500 Upper chesiperto Drive Bel Air, mo 21014

0065409

01/02/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of	Maryland / [-			Mental Hyg	iene	100	00000
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	rtificate of L	Jeath		eg. No. 2 (103	
	Physici	an						2. Date of Dea Month	Day	Year	3. Time of Death 8;17 P. M
- 1	/Medic Examir		Charles Robert Beach S 4a. Facility Name (If not institution, give street and number 1)			4b. City. Town, or	Location of Death	January		v of Death	
أوس	L Adiiii	iei	415 Cockeysmill Road	,		Reister			1	altin	
	Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last bir	thday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day		9. Birth	place (State or Foreign ntry)
	Director		220-20-6617 1X M 2□ F	80	Yrs.	WOTHIS Days	Hours Willi.	Dec. 24,	1928		sville,Md.
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Lo	cation					10d. Inside City Limits
	Maryli f sho	ē	Md. Baltimore			erstown					1 □ Yes 2 🖾 No
	the 1	Director	10e. Street and Number			10f. Zip Code		11	0g. Citizen of	What Cou	ntry?
	h with		415 Cockeysmill Road			21	136		US	A	
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be redthed at	Funeral	11. Marital Status 12. Was Deceder Armed Force		13. \	Vas Decedent of Hi Yes, specify Cuba		pecify Yes or No-			can Indian,
36	or its	by Fu	1 ☐ Never Married 2 Married 1 Yes 2	□ No		Tes, specify outball ☐Yes 21X2 No	Specify:	ricari, etc.)	Speci	nck, White,	eic. nite
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212	with giene. r than	E	Elementary/Secondary (0-12) 4 Years	%11ege D:	ir	of Commun	ications		Payrol:	l Pro	cessing
þ	al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, i	Maiden Surna	me)	
<u>la</u>	Menta Menta arked	2	Ralph E. Beach				Lucy	Leather	s		
Maryland	2 sho s and is m raum		19a. Informant's Name/Relationship (Type. Print)			g Address (Street a			-		,
e)	l and lealth am 27 ther t		Mrs. Sarah Jean Beach (Wi			ockeysmil					
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Expandred round be rectified at once.		1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from Sta	ate		sition (Name of natory or other place	i		20c. Location		
	nit. Partme ortani Injury		4 ☐ Donation 15 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Carro		Cremation Name and Addres		5, 2009 11824 F			l, Md.
ä	Per Sperior Sp		Camb Olini			ine Funer					, Md. 21136
			3a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	sed the death. Do r	not ente	er the mode of dying	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between
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	/Medical Examiner		resulting in death) Due to (or	as a consequence of	of):)					
	_ Adminior	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or	as a consequence of	\f\:					_	
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			IF FEMALE:						1		
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	0 0 0	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnar 9 ☐ Unknown 9 ☐ Unknown	nt at time of death n	5∟	Other (specify)				01141	Day Tour
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ecords,	quires in sign	d by						1 □ Y€	s 2 □No	3□ Prol	bably 4 🗆 Unknown
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ř	sician: The law certificate has birector, page 2 s	mo:	7					autops perforr	ned?	prior to co death? 1 ☐ Yes	mpletion of cause of
Vital R	clan: ertific ctor,	Be	25. Was case referred to medical examiner?				26. Place of Deat			100	25.00
<u>o</u>	Physician: r this certific ral director, I	P	1 Yes 2 No Hospital: 1 ☐ Inp	atient 2 ER/Out	<u> </u>		4 L Nursing Ho	ome 5 Reside			fy)
_	5 000	ertification:	Tatalara O T chang		ime of njury	28c. Injury Work	? _	28d. Describe ho	w injury occur	red	
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2	al or / s after il Dire	erti	4 ☐ Homicide determined building	, etc. (Specify)	,	,,		City or Town		oor or mare	a Houte Hambor,
	To the Hospital or Attendin, within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	cal C	29a. Certifier (Check only cont) 29 Medical Examiner: On the basic	est of my knowledge	, death	occurred at the tim	e, date and place,	and due to the c	ause(s) and n	nanner as s	stated.
	the H hin 24 the F mplete	Medical	and manner	stated.							
	So Viti	2	29b. Signature and title of certifier			29c. License	number	2	9d. Date signe	ed (Month,	Day, Year)
	17.1		30. Name and Alirect of seven with	of dooth (there 00=) (Tues 5	1)27	1123		117/	L02(
	12		30. Name and address of person who completed cause of	or death (Item 23a) (rype, F	~ ∧-~	55 3	Zerste	11-1-	<u></u>	m22/131
	Sta	te	31. Date filed (Month, Day, Year) 22. Reg	istrar's Signature	6-	V. F	-				, - 1, -1
	Registr	ar	JAN 0 6 2009 Land	a p. 19	PERI						

		Pleas	se Type or Prir State of Ma							9	
		1 - State Registrar			Cer	tificate of	Death		Reg. No	/ 11 11 0	00009
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/Medic	al			ount, Si	٠.			Januar		2009	12:50 P M
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r 28a	Director	Maryland Balti 10e. Street and Number	lmore	Coc	ckey	ysville 10f. Zip Code			10g. Ci	tizen of What Co	ountry?
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42 should be filed within 72 hours th and Mental Hygiene Tis marked other than "natural" traumatic event, II - Invefice Ex-	P	William S. 19a. Informant's Name/Relationshi	Blount, Sr.		Mailin	g Address (Street	Leola	Cather		Robi	
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permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau		21. Signature of Funeral Service L	censee Mala	K	22	Name and Addre	ss of Facility	Home of	Dula	nev Val	lev Inc.
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		23a. Part1. Inter the di ease, or c shock or heart fai ure. List o Immediate Cause (Fig. 1	nly one cause on each li	he death. Do n	ot ente	er the mode of dyir	ng, such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in	a. 54	215	£) =						days
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or At after d Direct in by	Certification:	4 ☐ Homicide determin	and 28e. Place of Inju	ury - At home, far c. <i>(Specify)</i>	m, stre	eet, factory, office		28f. Location City or To	(Street a own, Stat	nd Number or Ri e)	ural Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director, to	Ce	29a. Certifier 1 Certifying	Physician: To the best	of my knowledge.	. death	occurred at the ti	me date and pla	ce, and due to th	e cause(s) and manner a	s stated
le Hos 124 h le Fur	edical	(Check only 2 Medical E	xaminer: On the basis of	f examination and	d/or inv	estigation, in my o	pinion, death oc	curred at the time	e, date an	d place, and due	e to the cause(s)
To th Withir Comp	Me	29b. Signature and title of certifier	00 0			29c. Licens	e number	_	29d. Da	ate signed (Mont	th, Day, Year)
11		Renda	el Da	ulle	0	100	N564.	3	OL	10219	2009
4		30. Name and address of person w	ho completed cause of d	eath (Item 23a) (Type, F	Print)	Ω.	.110	- 01		th, Day, Year) 2009 24304
Sta	i o	31. Date filed (Month, Dav. Year)	Star CMD/	ar's Signature	1	100 Soute	まる	way B	act	D INC	01001
Sia Registra	- 1	31. Date filed (Month, Day, Year)	009 Census	B. 19	Jan	Kal		-			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 00010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year BAILEY RUBY 05.45 AM 0214 JAN 2009 /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner REHAB. GREATER LAUREL HEALTH AND LAUREL PRINCE GEORGE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Aug, 12, 1916 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days 1 🕅 M 2□ F 234-03-8125 Yrs. Clarksburg, W.VA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Madical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2/17 No Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4270 Bright Bay Way USA 21042 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give^A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1□ Yes 2No White 2 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) Be Jerome P. Lockhart Virginia L. Romine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marian L. Chichester 4240 Bright Bay Way, Ellicott City, Maryland 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lucbeck Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 01/05/09 Luckbeck, W. VA 22. Name and Address of Facility Witzke Funeral Home, Inc. 21. Signature of Funeral Service Lie MUIZ83 5555 Twin Knolls Road, Columbia, Maryland 21045 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, list only one cause on each line. Part1. Enter the diseas shock, or heart failure. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ()LD Years Examiner Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown tibulation Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Coronary Artery disease MOICHELLISTYH 200 No 1 Tyes 1 □Yes 2 □ No the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No Other: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death. Director: Af 2 ☐ Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide To the Hospital within 24 hours a To the Funeral D 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 53411 02 hd 2009 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 14300 Gallant Force 牛 210

20715

Bowle

State Registrar Shesadri

32 Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 01:20 AM Charles Samuel Bolden JANumo 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore washington Glen Burnie medical Center Anne Arundel Date of Birth (Month, Day, Year) 7/16/1922 (State or Foreign **Funeral** 1₺ M 2□ F 215-14-0942 86 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It a Modical Experiment must be notified at 1 ☐Yes 2 ☐ No Director MD Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7975 Crain Hwy. 21061 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 M Married Baltimore, Charles
Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Upholstery Cutter Upholstery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles James Bolder Sarah Anne Pumphrey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7975 Crain Hwy; Glen Burnie, Mrs. Irene Bolden / wife MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial 1/5/2009 Elkrige, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Services; 1 2nd Avd SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) brougsed lar **Physician** Accident Cere /Medical Due to (or as a consequence of): Examiner F. brill A tion trial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

24 hours after death.

24 hours after death.

25 hours all Director: After this certificate has been signed by the attending physician and attending in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy 1 □Yes 2 □Ho 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 7 40 1 Hipatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital o within 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature, and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAHIMON WAShinton Medical Center Mp 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 0 6 2009 Registrar

DHMH 17 Rev 1/2001

 β CAN hAM, OCA Baltimore, Maryland 21215-0036

	Phys /Me Exa
Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Examine Funeral Director	r	la. Facility Name (If not inc A)けんな Wか 5. Social Security Number 219-34-0910	shington 6. Se	Median) (7. Ag	e (In yrs.	2. (last birthday) Yrs.	G	en	Location of Death Runn If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 6/28/19	AN,	9. Birt	hplace (State or Foreign untry) VA
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	by Funeral	1216 Severn 11. Marital Status 1 Never Married 2 3 Widowed 4 D	⊠ Married	12. Was Decedent Armed Forces? 1 Yes 2				nt of Hi y Cuba	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	. 14	. Race - Ame Black, Whit	
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ath cert	by Physician/Medical	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 Yes 2 No 9 Unknown		23c. If yes, outcom 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 🗆 Fet	al death 3	□Ectopic pro		у		25	3d. Date of de Month	elivery Day Year
quires that n signed by	d by Pr	Part II. Other significant	conditions	contributing to death	but not re	sulting in the u	underlying ca	use giv	ven in Part I.			se contribute	to the cause of death? Probably 4
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To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	To Be	25. Was case referred to examiner? 1 Yes 2 No 27. Manner of Death		Hospital: 128 Inpat	jury	ER/Outpatie		A Oth	ry at	th (Check only ome 5 Res 28d. Describe	idence 6		ecify)
i or Attending after death. Director: Aft I in by the fun	Certification:	2 Accident	Pending investigatio Could not t determined	n De Dace of it	njury - At I	nome, farm, s	M treet, factory]Yes 2□No		(Street and own, State)		Rural Route Number,
le Hospita 124 hours ne Funeral pletely filled	Medical C	29a. Certifier 12 (Check only 2 one)	CertifyIng P Medical Exa	hysician: To the bes miner: On the basis and manners	of examir	nowledge, dea	ath occurred investigation	at the t	ime, date and place opinion, death occu	, and due to the irred at the time	e, date and	place, and d	ue to the cause(s)
To th withir To th comp	Me	29b. Signature and title	y for	an Ms			290	. Licen	se number 19415 Nigton V		JANU	e signed (Mo.	nth, Day, Year) 2009
4		30. Name and address of the Nry F	MANC	is MD.	death (Ite Ban strar's Sign	m 23a) (Type	Print)	sh.	Nigton 1	hedica	1 (-	enter	
Sta Registr		31. Date filed (Month, D	2009	Berein	A.	park	A. Carrier						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 12,18 per th g887 1-6-09 vt.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 00013 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death BRUTZKUS **Physician** JANVARY 0 <u>2</u> 7:38 PM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALLSTOWN NORTHWE ST HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1**√** M 2□ F 98 09/03/1910 Director 216-10-5318 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County show 10d. Inside City Limits "natural", or Items 23a or 28a-f shov dical Exa<u>miner must be notifled at</u> Director MD N/A BALTIMORE 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3008 FALLSTAFF ROAD, APT. B 21209 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes ₹ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 9 Specify WHITE Specify: 3 Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: if Item 27 Is marked other tha any Injury or other traumatic event, the Jonee. the 12 SALES GARMENT INDUSTRY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **CEILIA** 2 SAMUEL BRUTZKUS KLOMPUS CELLA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8512 ROAD POTOMAC, SAM GOLDBERG/COUSIN ATWELL MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 01/04/2009 |FINKSBURG, MD BETH JACOB 4☐9onation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PLEURAL EFFUSIONS **Physician** BILATERAL /Medical Due to (or as a consequence of): Examiner HEART FAILURE ONGESTIVE Sequentially list our diffund, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. ed by the a 9☐Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform page death? 1 ☐ Yes certificate 2 No 2 No 1∐ Yes 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes _ 2<u>□</u>√No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA This After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Matural Injury 5 Pending To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dew 63430 MO 2009 JANUARY 02 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

RAVITET

31. Date filed (Month, Day, Year)

JAN 05 2009

KHUNKHW

RANDALLSTOWN

5401 OLD COURT RD

2. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

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31. Date filed (Month, Dav. Year)

JAN 06 2009

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Dhoraini		Decedent's Name (First, Middle, Last)			2. Date of Death Month			3. Time of Death
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	Examin	er	4a. Facility Name (If not institution, give street and number) 925 CHESACO AVENUE	7,	Location of Death		4c. County	of Death LTIM (מסר
***	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,			ce (State or Foreign
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	ter de	Fun	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes . 2 ☑ No	 Was Decedent of H If Yes, specify Cuba 	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		e - Americar k, White, etc	
3-003p	within 72 hours after death with the Maryland iene. iene. Than "natural", or items 23a or 28a-f show he Modical Ever inc. must be notified at	þ	3 TWidowed 4 □ Divorced If Yes, Give Year or Dates:	1 □ Yes 2√∑ No	Specify:		Specify	WHIT	E
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and	thould be filed within 72 hours after death with the Marylan and Mental Hygiene. The marked other than "natural", or Items 23a or 28a-f show marked other than "natural", or Items 23a or 28a-f show marke event, the Moderal Expriner must be notified at	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, M.	aiden Surnam	e)	
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€ '	is rau		19a. Informant's Name/Relationship (Type. Print) JEANETTE BROUGHTON/DAUGHTER 92	lailing Address <i>(Street</i>		al Route Number, ROSEDAL	,	State, Zip C	,
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	/Medical Examiner		resulting in death) Due to (or as a consequence of): SACRAL WO		TITOM	16	/		
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VITAL	sian: ertifica ctor, p	Be C	25. Was case referred to medical examiner?		26. Place of Deat	th (Check only one		ILLITES Z	7_1/0
5	Physion this on	ပ္	1 XYes 2 → Hospital: 1 Inpatient 2 ER/Outpa		4 🗆 ivursing 🗖	ome 5 X Resider			
ם י	ding l h. After funer	tion:	27. Manner of Death ∠Natural 5 □ Pending (Month, Day, Year) ∠□ Accident investigation	ry Wor	ryat k? Yes 2 □ No	28d. Describe how	w injury occurr	ed	
DIVISION	Atten	ifica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm		100 2	28f. Location (Str		er or Rural	Route Number,
5	tal or rs afte al Dire ed in t	Certification:	4 ☐ Homicide determined building, etc. '(Specify)			City or Town,	State)		
:	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, control of the pass of examination and/one) 2 ☐ Medical Examiner: On the basis of examination and/one and manner stated.	death occurred at the ti or investigation, in my o	me, date and place opinion, death occu	, and due to the ca rred at the time, da	iuse(s) and ma ite and place,	anner as sta and due to t	ited. he cause(s)
1	To the within To the Complex c	Me	29b. Signature and title of certifier	29c. Licens			ld. Date signed		
	1		White I Bellenter mos	Ds	733/	2	/-	2 - 2	009
	11		30. Name and address of person who completed cause of death (Item 23a) (Ty	rpe, Print)	VI I	,	· , ,	p 11	2/22y
	Sta	te.	31. Date filed (Month, Day, Year) 32. Registrar's Signature	505 If	prih O	aj vier	rule	15alt	mir MD
	Registr		JAN 0 5 2009 Sentia B. So	Wed					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 02^{Day} Physician January Raymond E. Brenner, Jr. 12:41PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Good Samaritan Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 08-31-1927 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 81 Yrs. **Funeral** 1 X M 2 □ F Maryland Yrs. 216-24-8899 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Mardical Exercites must have any injury or other traumatic event, it is Mardical Exercites must have 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No **Funeral Director** Maryland N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21214 3009 Evergreen Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Be Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Display Designer Accent Display Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond E. Brenner, Sr. Viola Dietz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 42 Sequoia Road Mrs. Barbara Fudjack - Cousin Severna Park, Maryland 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Hilltop Service Corporation 01/06/2009 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 5305 Harford Road 21. Signature of Funeral Service Licenses Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cruse on each list. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Neumonia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated sease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed the burlal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical for use as 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 □No 23d. Date of delivery 3 Ectopic pregnancy Month Day Ye ar 5 Other (specify) ייו אין על שופעוער: אופר this certificate has been signed by the ifilled in by the funeral director, page 2 should be detached Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 | Yes 2 | 1 | 10 Medical Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cortifier 500 d Sarantan Hospill Beltime 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 5 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

obert S. Ciapur		State of Maryland / Depa	artment of rtificate of			g. No. 200	9 0001
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)			2. Date of Death		3. Time of Death
ledical Exami		Robert S. Ciapura			January 1,	2009	1242 hrs
		Facility Name (if not institution, give street and number) 3814 Biddison Lane	4	b. City, Town, or Location of I Baltimore	Death	4c. County of Death	
Funaral		5. Social Security Number 6. Sex 7. Age (In yrs. I	ast birthday)	If Under 1 Year If Under 2	24Hrs. 8. Date of Birti	h(MM/DD/YYYY) 9. Biri	thplace (State or
Funeral Director		219-26-4048 1X M 2 F	70 Yrs.	Months Dave Hours		Foreig	Maryland
ķ	ļ	Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Location	on			10d. Inside City Limits
Aaryland 28a-f show any 1 at ouce				re City			1 X Yes 2 No
ryland a-f sh	ector	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Cou	ntry?
h the Maryland 3a or 28a-f sho	Dire	3814 Biddison Lane		21206		U.S.A.	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 X Married Armed Forces?		s Decedent of Hispanic Origines, specify Cuban, Mexican, F		14. Race - Amer White, etc.	can Indian, Black,
er dez		3 Widowed 4 Divorced If Yes, Give Year	1	Yes 2 X No specify:		Specify: Whi	te
urs afi fural	a p	15. Decedent's Education (Specify only highest grade completed)	16a. Deceden	t's Usual Occupation (Give kir	nd of work done	16b. Kind of Business/	Industry
6 172 ho an "na cal Ex	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)		ost of working life. DO NOT us O Technicia		Governm	ent
003 withir grene.	E I	12 3	- Madi		Name (First, Middle, N	Asiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene, marked other than c event, the Medica	Be C	Stephen Ciapura			ohanie Ay		_
212 ould be Ment mark ic ever		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street and Numb	er or Rural Route Num	ber, City or Town, State	e, Zip Code)
MD id 2 sho alth and m 27 is		Danny Ciapura- Son		Biddison La		more, MD 2	
nore, MD 21215-0036 ages I and 2 should be filed within 72 nt of Health and Mental Hygiene. It: If item 27 is marked other than "other trannantic event, the Medical		1 V Rurial 2 Cremation 3 Removal from State	crematory or oth		Date 0 1 /06/ 0 9	Parkvill	
Baltimore, permit Pages lar Department of Hee Important: If ite		4. Donation 5 Other Specify:		cemerery			
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than hijmry or other transmark event, the Medical	إ	2 Signature of Funeral Service Licens e	EV A	lame and Address of Facility ins funeral)O Harford F	Chapel &	Cremation	Services
Physician	A	28a. Part I. F ter the disease, or complications that caused the death	n. Do not enter th	ne mode of dying, such as car	rdiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	Ų	failure list only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atheroso	lerotic Cardi	ovascular Disease			Death
)		or condition resulting in death) Due to (or as a consequence	of):				
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	of):				
Si. of (X)	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence	of):				
D, be executed sician and purial - transi	edical E	d					
60, cate be physici he buri	Med	IF FEMALE: 23c. If yes, outcome of pre	gnancy			23d. Date of deliver	
687 certifi nding se as t	ian/	23b. Was decedent pregnant in the past 12 months?	-		pregnancy	Month	Day Year
Box 68760, he death certificate be the attending physic hed for use as the burned for us	Physician/M	1 Yes 2 No 9 Unknown	5 Ot	her (Specify)			
, P.O. Boy res that the death signed by the att		Part II. Other significant conditions contributing to death but not	resulting in the t	underlying cause given in Par	t I. 23e. Did to	obacco use contribute to	the cause of death?
S, P	Completed by				24a. Was		utopsy findings available
cords, F law requires has been sign	plet				autop		completion of cause of
tal Rec	Com				1 Yes		es 2 No
Vital Rec ysiciau: The I his certificate I	Be	25. Was case referred to medical examiner? Hospital: Inpatient 2	ER/Outpatient	26.Place of Death (Nursing Home 5	Residence 6 V Other	er: Scene
of Viiing Physical After this	2	27. Manner of Death 28a. Date of Injury	28b. Time of			how injury occurred	
On C	tion	1 Natural 5 Pending (Month, Day, Year)		1 Yes 2	No		
Division of Vital Records, pital or Attending Physician: The law requirours after death. Incral Director: After this certificate has been sfilled in by the funeral director, page 2 should it.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	home, farm, stre	et, factory, office building, etc	c. 28f. Location (or Town, S		ural Route Number, City
<u> </u>		29a. Certifier 1 Certifying Physician: To the best of my knowle	dge, death occu	rred at the time, date and place	ce, and due to the caus	se(s) and manner as sta	ited.
To the Hos within 24 h To the Fun	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or investiga		curred at the time, date		
	Σ	29br Signature and title of certifier		29c. License number O.C.M.E.		January 5, 2009	
		Call 1111	m 23a)	O.O.IVI.L.		1, 0, 2000	
541		30. Name and address of person who completed clause of death (Ite Zabiullah Ali, M.D. Assistant Medical Examine		nn Street, Baltimore, M	MD 21201		
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signa	iture				
Regis		JAN 0 6 2009 Same	1. 16	arks			
DHMH 17 Rev 1/2	2001		ORIGINA	AL.			

GLENN T. CUNNINGHAM 09-00036 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day January 2, 2009 0510 hrs Medical Examiner enn 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Baltimore 1100 block Orleans Street 9. Birthplace (State or If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** oreign Min Hours Director Country) Maryland 1 M 2 F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h Counts 10c. City. Town or Location Yes 2 No ten 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once. lary lan Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 203 Dak Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 11. Marital Status Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes Pages 1 and 2 should be filed within 72 hours after tent of Health and Mental Hygiene. Yes, Give Year Yes 2 No specify: Widowed Divorced If item 27 is marked other than "natural", þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 Cashier 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Desserae Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Tyce rint) Simmons Oak Dessevac 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State Woodlawn - Cemeter Other Specify: Donation 5 5 21. Signature of Funeral Service Licen 22. Name and Address of acility Himore 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaf proximate Interval Physician etween Onset and failure. List only one cause on each line /Medical Death a Gunshot Wounds (2) of Chest and Left Arm Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last attending physician and or use as the burial - transi Physician/Medical UNPENDED AMENDED The law requires that the death certificate be Records, P.O. Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death detached for use as past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ Yes 2 ✓ No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has performed? death? Yes 2 ✓ Yes 2 No certificate After this certific funeral director, p To the Hospital or Attending Physician: within 24 hours after death 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital æ examiner? Hospital:, Other DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 ٩ 1 V Yes No 28a. Date of Injury funeral 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury Certification: Subject shot Jan 2, 2009 0459 hrs Natural Yes 2 V No To the Funeral Director: completely filled in by the Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 1100 block Orleans Street, Baltimore, MD determined (Specify) Multi-Family Apt. 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number January 2, 2009 O.C.M.E. no. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD 31. Date filed (Month, Day, Year 32 Registrar's Signature. State Registrar ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

velyn Clemens		State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009										
Physiciar Medical Examin	n/ er	Decedent's Name (First, Middle,Last)	Evelyn				2. Date of Death Month D January 2, 2		19	ne of Death 132 hrs		
		4a. Facility Name (if not institution, give Maryland General Hospital			o. City, Town, or L Baltimore		I	4c. County of De	(A			
Funeral Director	2	5. Social Security Number 6. Sex 247-25-9037 1		rs. last birthday) He Yrs.	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth(MM/DD/YYYY) 9.11 For	eion	Maryland		
Maryland 28a-f show any 1 at once.		Usual Residence of Decedent 10a. State 10b. County Mayland NII	10c.	City, Town or Locatio	Bat	timore				res 2 No		
death with the Maryland or items 23a or 28a-f sho	Dire	10e. Street and Number 435 Cummings	ct.		10f. Zip Code	21201		. Citizen of What C	A			
ja	by Fune	1 Never Married 2 Married	12. Was Decedent Ever Armed Forces? 1 Yes 2 1 Yes, Give Yeer or Dates:	No If Ye	es, specify Cuban,	specify: on (Give kind of w	Rican, etc.)	14. Race - Arr White, etc Specify: B	lack	۷		
5-0036 led within 72 hours af Hygiene 72 hours af other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		ost of working life. Un-emp	DO NOT use retir	ed)	N	4			
1215- Id be filed Mental Hyg narked off	8	17. Father's Name (First, Middle, Last) TWI S Clemons 19a. Informant's Name/Relationship (Ty)	pe, Print)	19b, Mailing		8.Mother's Name EVELYA t and Number or F	Hill	iden Surname) er, City or Town, St	ate, Zip C	Code) 3 400 C		
MD and 2 sho salth and 2 is the 27 is raumat		Helen Clemans — 20a. Method of Disposition 1 Burial 2 Cremation 3	sister	20b. Place of Disposi grematory or oth	er place)		BaHina	20c. Location - City		21225 State		
Baltimore, permit, Pages I a Department of He Important: If it injury or other I		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licens	4		Cemeter ame and Address		KerFung KerFung KerRal	Landsdo	whe ldn	Hayland		
Physician Medical Examiner				osclerotic Cardi			r respiratory arres	t, shock, or heart		proximate Interval tween Onset and Death		
	iner	Sequentially list conditions, b	ue to (or as a consequer						+	.		
	al Examiner	(Disease or injury that initiated events resulting in death) Last d.	ue to (or as a consequer	nce of):								
60, cate be exe physician in he burial -	Medical	UNPENDED	AMENDED 23c. If yes, outcome of	pregnancy				23d. Date of deli	very			
Box 68760 death certificate b the attending physical dor use as the bu	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 4 Pregnant at time 9 Unknown	of dooth	tal death 3 [ner (Specify) _	Ectopic pregna	incy	Month	Day	Year		
res that the d signed by the	ᅙ	Part II. Other significant conditions Morbid Obesity, Diabetes	_	not resulting in the u	nderlying cause g	iven in Part I.		acco use contribute 2 No 3				
ords aw requi	Completed						24a. Was ar autops perform 1 Yes 2	y prior ned? deati	to compli	findings available etion of cause of		
'ital Re sician: The is certificate irector, page	a		ospital: 1 Inpatient	2 V ER/Outpatient		of Death (Check Other		Residence 6 0	ther:			
vision of Vital Recontacted in the late of the death. Sirector: After this certificate in by the funeral director, page	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day,Year)	28b. Time of I	njury 28c. Inju	ry at Work? Yes 2 No	28d. Describe ho	ow injury occurred				
Division Hospital or Attent 24 hours after death Funeral Directors	Certification:	3 Suicide 6 Could not be determined	e 28e. Place of Injury (Specify)				or Town, Sta			oute Number, City		
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examiner:	n: To the best of my kno On the basis of examinat and manner stated.	owledge, death occur tion and/or investigat	red at the time, dation, in my opinion	ate and place, and	due to the cause at the time, date a	(s) and manner as nd place, and due t	stated. to the cau	se(s)		
→ + 3 + 3	×	29b. Signature and title of certifier Man Brasse	11 mo		29c. Licens			January 5, 20		ay, Year)		
7		30. Name and address of person who co Melissa Brassell, MD As	sistant Medical Ex	aminer 111 F	enn Street, B	Baltimore, MD	21201					
Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrac's S		Ved .							
DHMH 17 Rev 1/20	001		•	ORIGINA	L							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month, Year **Physician** Elias Gilberto Calderon-Lovo 2009 03 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MD Agnes Baltimore HUSDITAL If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Social Security Numbe **Funeral** 1 XM 2 □ F Yrs. N/A 01/03/2009 4 MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1XXYes 2 ☐ No Director Baltimore City Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21230 2801 Eastshire Drive U.S.A. **Completed by Funeral** Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married E1Baltimore, Maryland 21215-0036 1X Yes 2□ No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced Salvador Hispanic 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Man n Dependent Not Self Supporting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gilberto Calderon Deisy Lovo ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Gilberto Calderon / father 2801 Eastshire Drive, Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 01/07/09 Glen Burnie, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD MO1357 Singleton Funeral & Cremation SErvices, P.A. 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, scheert failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ulmonary Hemorrhage hours /Medical Due to (or as a consequen a of): Examiner ongenital Mrway Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner 2 hours MULTIPIC (C)
Due to (or as consequence of): that the death certificate be executed Congenital and burial-tran Division or Vital Records, P.O. Box 68760, physician the attending p for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) the a 9☐Unknown 9 Unknown by s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has t funeral director, page 2 s autopsy Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No Inpatient 2 ER/Outpatient 3□ DOA ۴ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: death the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide ō Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0060780 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Caten Avenue Bulhmor, MD Curtin Molonty. MD St. AGNES 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Cassandra Colen		I- For State	tate of M	aryland		rtment of tificate of	Health and	d Mental H		2	009	0002
Physicia		Registrar 1. Decedent's Name (First, Mid	dle,Last)			in out		Tall '	2. Date of Deatl	g. No.		ne of Death
Medical Examin		Cassandra	C	olema	n			01.1	January 1,	Day Year 2009	16	00 hrs
* In		4a. Facility Name (if not instituti 3800 Belvedere Aver		and numbe	r)		4b. City, Town, or Baltimore	Location of Deat	h	4c. County of	Death	
Funeral		5. Social Security Number	6. Sex	7. A	ige (In yrs. la	st birthday)	If Under 1 Yea	r If Under 24Hr	s. 8. Date of Birt	h(MM/DD/YYYY)		(State or
Director		217-98-1512	1 M 2	XF	42	Yrs	Months Day	s Hours Mi	.09–19	-1966	Foreign Country)	MD
	3. 1/	Usual Residence of Decedent			140. 0.4.	Town or Locat		-1			1104.1	nside City Limits
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13407 hours after death with the Maryland natural", or items 23a or 28a-f show Examiner must be notified at once.	ig	MD Ba	ltimore		Mi	ddle R	iver		110	og. Citizen of Wha		
he Ma or 28	Director		ma1a				2122	00		USA		
with t		13 Benoni Ci	12. W		nt Ever in U.S		as Decedent of His	spanic Origin? (§	Specify Yes or No-	14. Race -	American Inc	dian, Black,
3 death death nr iten	Funeral	1 Never Married 2 X	Married A	rmed Force Yes	s? 2 X No	If Y	es, specify Cubar		to Rican, etc.)	White,		
safter	by		ivorced If Yes, or Date	Give Year es:		1	Yes 2XX No			Specify:	Black	
		15. Decedent's Education (Sp Elementary/Secondary (0-12		ollege (1-4 o			nt's Usual Occupa nost of working life			16b. Kind of Bus	iness/industr	y
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5-0036 lide within 72 Hygiène. I othèr than '	S	17. Father's Name (First, Middl	. ,	***					ne (First, Middle, M			
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imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental I funt: If item 27 is marked or other transmitte eveut.	2	19a. Informant's Name/Relation		•		1	- ,		Rural Route Num Baltimo		, State, Zip C 21206	ode)
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Baltimore, permit. Pages I and Department of Heal Important: If iten injury or other tra		1 X Burial 2 Cremati		moval from	State	rematory or of		,	00 2000	DAT TO	 MD	
altin nit. P. artme oorfan		4 Donation 5 Other 21 Signature of Funeral Service			M		CEMETERY Name and Addres		09-2009			F.H., Inc
E P P E	1 3	James 9.	m	orto	7	17	'01-31 La	urens S	t. Balti	more, MD	21217	
Physician Medical	. 39	23a Part I. Enter the disease, failure. List only one caus Immediate Cause (Final disease	se on each line).			the mode of dying			est, shock, or hea	rt App Bet	roximate Interval ween Onset and Death
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Sox 6876(leath certificate e attending phys	ician/Me	23b. Was decedent pregnant in past 12 months?	the 1	Live birth	at time of de	oth	etal death 3	Ectopic preg	nancy	Month	Day	Year
Box e death c the atten	S	1 Yes 2 No 9 🗸 L	Inknown 9	Unknown		5 0	ther (Specify)					
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Division tal or Attendi rs after death al Director:	icat	2 Accident for	vestigation 2		,		eet, factory, office	building, etc.	28f. Location (Street and Number	er or Bural Ro	oute Number, City
Division or At the pours after de numeral Direct y filled in by	Certification:		ould not be termined	Specify)	sce	ene			#212 B	altimore	, MD	ere Ave
To the Hosp within 24 ho Completely fi	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	xaminer:On th	e basis of e	xamination a	ge, death occu nd/or investiga	urred at the time, o	date and place, a	nd due to the caused at the time, date	se(s) and manner and place, and d	as stated. ue to the caus	se(s)
100 P 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Med	29b. Signature and title of cert		nanner state	ed		29c. Licen	se number	OME	29d. Date sign	ed (Month, D	ay, Year)
		1/1 2	1 -1.	1-			0.0	.M.E.		January 2,	2009	
1 O'bend		30. Name and address of pers		eted cause of	of death (Item	23a)				1		
1		Theodore M. King, J	r., MD. A	Assistant	Medical E	xaminer	111 Penn S	treet, Baltimo	ore, MD 2120	1		
St Regist	ate trar	31. Date filed (Monto, Day Yea	09 Se	32. Regis	urars signatu	re	,			<u>.</u>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 00022 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Ye ar **Physician** Jean Laura Ann 5.10 Carter AM January /Medical 200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Union Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) Year)
Months Days Hours Min. Nov 1, 1946 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF 215-44-2460 62 Kentúcky Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21211 2168 Druid Park Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 🕅 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner Bar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Edward Cummins Dorothy Bradley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; if item 27 is any injury or other trau Carey James Hill/son 2168 Druid Park Dr. Baltimore, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State W. Arundel Crematory 01/05/09 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Going Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Usease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Severe sopris the burial-tran Due to (or as a consequencé of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ပ္ 28a. Date of Injury (Month, Day, Year) 27. Mannel of Death 28h Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

or Attending Physician; The law requires that the death certificate be executed P.O. Box 68760,€ Records, Division of Vital within 24 hours after death

To the Funeral Director:
completely filled in by the

> 1 State Registrar

Medical

NaZI Farsi Union 31. Date filed (Month, Day, Year) 6 2009

determined

4 ☐ Homicide

29b. Signature and title of certifier

29a. Certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

hospital

AT 2438946

lanuary

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 16b per fh 8887 1-6-09 vt State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registra 00023 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 03 2009 Pear **Physician** BESSIE COHEN 5:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTH OAKS HEALTHCARE CENTER BALTIMORE BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🖸 F 212-28-2018 97 Director 01/08/1911 RUSSTA Usual Residence of Decedent the Maryland 10a State 10b. County 10d. Inside City Limits 10c. City. Town or Location 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, The Medical Examinating the multified at MD Director BALTIMORE BALTIMORE 1 ☐ Yes 2 🔽 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 725 MT. WILSON LANE USA 21208 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give V Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 WHITE 1 □Yes aNNo Specify <u>م</u> 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 in and Mental Hygiene. 7 is marked other than "n PHARMACEUTICAL Elementary/Secondary (0-12) College (1-4or 5+) OWNER PHARMACEUDICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARCUS KATZ SHULMAN ဂ္ JENNIE 19a. Informant's Name/Relationship (Type. Print)
ELAINE ELKIN/DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If Item 27 is
any Injury or other trau 7 SLADE AVENUE, #508 BALTIMORE, MD 21208 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 X□ Burial 2 □ Cremation 3 □ Removal from State ARLINGTON CHIZUK AMUND 01/4/2009 BALTIMORE,MD H Depation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature Funeral Service <u>B900 REISTERSTOWN ROAD PIKESVILLE, MD 21208</u> 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Arthenschentic Heart disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Artery Cronary if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner g physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and a Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending p as IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? cate has t page 2 s 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No this certific al director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 00053337 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sude 200 Reisterstown, Md 21136 Secry 25 Main Street 31. Date filed (Month, Day, Year) Registrar's Signatur State JAN 0 5 2009

DHMH 17 Rev 1/200

Registra

31

1 - For State Registra 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 02:14 A M CHANEY ELENORA H. 2009 JANUARY 03 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours Min. 1 □ M 2 □XF 215-01-7256 January 3, 1918 Maryland 90 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a. State 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must by notified at 1 ☐ Yes 2 No Dundalk Directo Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21222 101 Center Place Apt 505 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No If Yes, Give Year or Dates: Specify. Specify: White ð 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 8 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked, any injury or other traumatic evonce. Anna Schmidt George F. Kraft ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1977 Guyway, Dundalk, Maryland 21222 Kevin Chaney 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) January 6, 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Baltimore, Maryland Bayview Crematory 2009 4 ☐ Donation 5 ☐ Other (Specify) Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21. Signature of Funeral Service License 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DAYS ACUTE RENAL FAILURE /Medical Due to (or as a consequence of): Examiner VEARS HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown CLOSTRIDIUM DIFFICLE COLITIS Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: page 2 2 No 1 ☐Yes 2 ☐ No certificate 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009

00024

P.O. of Vital Records, Physician: funeral Division or Attending s after death. the filled in by To the Hospital of within 24 hours a To the Funeral C completely filled

> State Registrar

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier (Check only

4 Homicide

29b. Signature and title of certifier

MELISSA D MORGAN

5 ☐ Pending investigation

6 ☐ Could not be

determined

milissa D magaines

5 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVENUE 4940 EASTERN 32. Registrar's Signature

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number RES-000

1 ☐ Yes 2 ☐ No

28a. Date of Injury (Month, Day, Year)

BALTIMORE MD 21224

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

JANUARY 03, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00025 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear **Physician** MARY HILDA COUNSELMAN 2:15 A January 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore County 1055 West Joppa Road, #230 Towson 8. Date of Birth (Month, Day, Nov 30, 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Days 219-22-7409 86 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location show 10a. State ed other than "natural", or Items 23a or 28a-f show event, the Medical Evandon and be notified at Director 1 ☐ Yes 2 ☑ No Maryland Baltimore County Towson Pages 1 and 2 should be filed within 72 hours after death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21204 USA 1055 West Joppa Road, #230 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Johns Hopkins School Department of Health and Mental Hygiene Important: If item 27 is marked other than "any injury or other traumatic event, I'm Magone. College (1-4or 5+) Elementary/Secondary (0-12) of Medicine Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbara Teresa Smith Charles Claude Counselman, Sr. 19a. Informant's Name/Relationship (Type. Print) (Brother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1055 West Joppa Road, #248, Towson, Maryland 21204 Charles C. Counselman, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State New Cathedral Cemetery 1/6/2008 4 Donation 5 Other (Specify)

21. Signature of Funeral Servicities Baltimore, Maryland MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Disseminated months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 □Yes 2 12No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٥ 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) To the within 2 To the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who comple

JAN 05

31. Date filed (Month, Day, Year)

Falls

gause of death (Item 23a) (Type, Print)

Luthervill

\$2. Registrar's Signature

D0018410

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 00026 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** EMMA MOSNER CARROLL 2000 0:00 19 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 15900 YORK RD SPARKS BALTIMORE 8. Date of Birth (Month, Day, Year) 09/26/1918 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 □ M 2 F MARYLAND 220-05-1204 90 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show Director 1 ☐ Yes 2 No MD BALTIMORE SPARKS 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code 15900 YORK RD 21152 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 2 3 Widowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12YRS College (1-4or 5+) ANTIQUES BUSINESS OWNER ANTIOUES / Tan...
of Health and ...
If item 27 is marked ou...
*her traumatic event, II/ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROBERT D. MOSNER LYNDE ELIZABETH ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILEY HAWKS (POA) 15900 YORK RD SPARKS, MD. permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr once. 21152. Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JOHNS LUTHERAN 01/10/09 PHOENIX, MD. 22. Name and Address of Facility
HENRY W. JENKINS & SONS CO.
16924 YORK RD MONKTON, MD. 2 Weller Man. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed burial-tran Due to (or as a consequence of): 68760. Physician/Medical SS IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy The certificate 2 🗆 No 1 □ Yes 2 🛛 No 1 ☐ Yes Division of Vital Hospital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 🗵 Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) widen AN Baltoney NO 21201 31. Date filed (Month, Day, Year) 2. Registrar's Signature JAN 05 Registrar

DHMH 17 Rev 1/2001

CARC.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JAMOBARY PAY. 2 CHENS 6:10F **Physician** KATHERINE M. CAMPBELL /Medical 4b. City, Town, or Location of Death 4c. County of Death imore 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center Examiner If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, Year) AUG. 25, 1926 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1□ M 2□ F 82 MD 212-32-6459 **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Examiner must be nothed as once. 1√Yes 2□No Director BALTIMORE MD N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21206 USA 7109 WILLOWDALE AVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE If Yes, Give Year or Dates: Specify: þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WAITRESS RESTAURANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be AGNES UNKNOWN FRANK ROBANOWSKI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MOOREHEAD CITY, NC 28557 114 COTTAGE ROW JEAN LESSNER-DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD GARDENS 1/5/09 OF FAITH 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 21. Signature of Funeral Service Licensee 6415 BELAIR RD BALTIMORE, MD 21206 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure 24st only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPTIC SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CLOSTRIDIUM DEFFICILE COLITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed nis certificate has been signed by the attending physician and idirector, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown ACUTE RENAL FAILURE Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed yes 2 2 No 1 🗌 Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes npletely filled in by the funeral 27. Manner of Death 1 Natural 2 Accident Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified lella M.O 200 ARUMAL 02 D41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON, MARYLAND 21204 OSLER DRIVE 7601 MEHTA, M. D. JOGINDER F. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 0 5 2009 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 0555P M Dunkes VIRGINITA 2009 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital Baltimore City | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, May 19, May 19, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 62 490-50-6822 Director Missouri Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits show Item 27 is merked other than "natural", or Items 23a or 28a-f sho other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Baltimore Glen Arm 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21057 United States 4709 Breidenbaugh Lane Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White þ Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Department of Health and Mental Hveilmportant: If flem 2.7 is meritany or other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alva Hoffman Aubrev Hoffman ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Dunkes - Spouse 4709 Breidenbaugh Lane, Glen Arm, Maryland 21057 20a. Method of Disposition 20c. Location · City or Town, State 20b. Place of Disposition (Name of Date competery crematory or other place)
Moreland Memorial Park
Cemetery 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan. 7, 2009 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Evans Funeral Chapel & Cremetion Services — Parkville 8800 Harford Road, Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. immediate Cause (Final Myeloid **Physician** Acule 2 months disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any loading to him did in a cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of The law requires that the death certificate be executed and the burial-transit resulting in death) Last Due to (or as a consequence of) attending physician Box 68760, Physician/Medical as IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy director, page 2 should be detached for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown P.0. the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performe 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 2 ER/Outpatient 3 DOA 1 🗷 Inpatient 6 Other (Specify) ၉ this completely filled in by the funeral Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation Director: After 1 Natural Injury 1 🗌 Yes 2 No death. 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide hours a within 24 hours a the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

benhar led (Month, Day, Year) State

29b. Signatur

32. Registrar's Signatur backet

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

January

29d. Date signed (Month, Day, Year)

2009

Registrar

RES - 000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death -Month **Physician** Ichard Frevett anuar /Medical 4a. Facility Name (If not institution, give street and number)
Baltimore Rehabilitation Extended Care 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 M 2 □ F March 11,1927 South Carolina 181-20-4746 81 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Modical Examinat must be redified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes X No Director Maryland Baltimore Nottingham 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 21236 U.S.A. 4821 Sennett Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 1045 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1945 Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: ۾ Specify: White 3 ☐ Widowed 4 ☐ Divorced 1946 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lillian Everett Romeo Dewarf ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4821 Sennett Ct. Nottingham, Maryland 21236 Barbara DeWarf - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other p Evans Fineral Chapel Bel – Air Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 01/06/2009 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Exams Funeral Chapel & Cremation Services — 8800 Harford Road, Parkville, Maryland 21234 21. Signature of Funeral Service Licensee Parkville 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear railure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) Izheimers isease **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐No sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform ours after death. eral Director: After this certificate I filled in by the funeral director, pagr 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Rehabilitation 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manuar of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number D41365 WE MA January 2, 2009 30. Name and address of person who completed cause of geath (Item 23a) (Type, Print) Raven Boulevard, Baltimore, MD, 21218 reovae

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) -

ORIGINAL

A. Garles

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#20b per FH G887 1/6/09 WS State of Maryland Department of Health and Mental Hygiene Reg. No. 2009 00030 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician 1:13 PM Durm Cova 2009 January 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A St. Agnes Hospital Baltimore 8. Date of Birth (Month, Day, Ye Nov. 12, If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 71 Yrs. Birthplace (State or Foreign
Country) . 1937 **Funeral** 217-34-6171 1 □ M 2 💢 F Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matter according. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Baltimore Halethorpe 1 ☐ Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 2779 Yarnall Road 21227 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Enteprenuer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles H. Clark Mary Dolores Wehberg မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7999 Woodhall Dr., Glen Burnie, MD 21061 Karen Garrity 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 1-6-2009 1 Burial 2 Cremation 3 Removal from State Atlantic Crematory Glen Burnie, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Non. ST elevation 24 hours Physician disease or condition resulting in death) /Medical **Examiner** hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Du (or as a consequence of) Division or Vital Records, P.O. Box 68760, Years Be Completed by Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funera 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medigal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0062273 01,2009 January 900 Caton Ave 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shahriar Amin MD Baltimore MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JAN 0 6 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year January **Physician** 7:09 AM JOHN FRANCIS DEVANNY, SR. 02 .2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 54 Agnes
5. Social Security Number Hospital 8. Date of Birth (Month, Day, Year) JUNE 22, 1931 Birthplace (State or Foreign Country)
 MA If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 1 XXM 2 □ F Months Days Hours Min. Yrs. 77 219.28.7231 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Exponentment be notified at 1 ☐Yes 2√XNo Director LINTHICUM MD ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 NURSERY RD. 21090 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Xes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: WHITE ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BANKING MIDDLE MANAGEMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EDWARD DONALD DEVANNY SR BARBARA McMANUS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8 201 NURSERY RD., LINTHICUM, MD 21090 WIFE PATRICIA E. DEVANNY 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of I
Important: If ite
any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State NEW CATHEDRAL CEMETERY JAN 8, 2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu o Funeral Se vin 22. Name and Address of Facility FINK FUNERAL HOME, P.A. **GREGORY** M01148 426 CRAIN HWY. S., GLEN BURNIE, MD Approximate Interval Between Onset and Death om dications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. 23a. Part 1. Enter the disease, o shock, o heart failure. List Immediate Cau . (Final disease or conditi resulting in death) **Physician** Septic /Medical Examiner Colitis Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Bacteremia attending physician and for use as the burlal-tran Due to (or as a consequence of) 68760 IF FEMALE: P.O. Box 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 1 ☐ Yes 2 🕱 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P20998 January, 02, 2009

Registrar
DHMH 17 Rev 1/2001

State

VISHNY

31. Date filed (Month, Day, Year)

Caton

900

Baltimore

Ave.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EVUTI,

MD

32. Registrar's Signature

Baltimore. Maryland 21215-0036

		For State Registrar	Ce	rtificate of	Death		g. No. 20(19 000:			
hysicia /Medic		1. Decedent's Name (First, Middle, Last) Joan A. D'Alfonzo				2. Date of Death Month Januar	Day Yea	3. Time of Death			
/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death	0011/0011	4c. County of De	eath			
		21 Larbo Road		Mille	rsville		Anne Ar	cundel			
uneral			yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year) 9. E	Birthplace (State or Fore Country)			
rector		214-30-5553 1 □ M 2 N F 7 Usual Residence of Decedent	4 Yrs.	World's Days	Tiours Willi.	6/30/19	34	MD			
WOL			City, Town or Lo	ocation				10d. Inside City Lim			
Ba-f sl	Director	MD Anne Arundel	Miller	csville				1 □ Yes 2 🔀			
or 2		10e. Street and Number		10f. Zip Code		10	g. Citizen of What	-			
s 23s	Funeral	21 Larbo Road		211			U.S.A.				
item Er a	Ę.	11. Marital Status 12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of F If Yes, specify Cub	lispanic Origin? (Spe an, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Al Black, Wi	merican Indian, hite, etc.			
?? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exmitirer must be retified at	<u>م</u>	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify:	white			
natura Sicel E	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occup	pation during most of worki	ina 1	6b. Kind of Busine	ss/Industry			
Important: If item 27 Is marked other than "n any injury or other traumatic event, the Medionce.	ם	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retire omemaker	during most of worki d)		Own Ho				
nt, th		17. Father's Name (First, Middle, Last)	110	memaker	18. Mother's Name	/First Middle M		me			
ed of	Be	Albert Wengert				ine Laugl					
mark	ဥ	19a. Informant's Name/Relationship (Type. Print)	10h 14-717	na Address /Cim-+	and Number or Rura			o Zin Codol			
7 Is r traur		Mr. Charles D'Alfonzo/husba	1					e, Zip Code)			
em 2 ther					d; Millers		Oc. Location - City	or Town, State			
10ro		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State		osition (Name of matory or other pla							
njun			tlantic	Cremator	y 1/6/	2009 G.	len Burni	cremation			
any i		21. Signature of Funeral Service Licensee						MD 21061			
-		23a. Part1. Enter the disease, or complications that caused the c						Approximate			
sician edical miner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a condition or		UNE CAN	VCIN			Interval Between Onset and Deeth			
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	sequence of):								
attending physician and for use as the burlat-transit	dical Examiner	Due to (or as a consequence of):									
by the attending I tached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of prediction in the past 12 months? 1 □ Live birth 2 □ in the past 12 months? 4 □ Pregnant at time 9 □ Unknown		23d. Date of Month	delivery Day Year						
igned be de	þ	Part II. Other significent conditions contributing to death but not	resulting in the u	underlying cause giv	ven in Part I.			e to the cause of death			
cate has been s page 2 should	Completed					24a. Was an autopsy perform	prior				
∰ 'ö'	Be (25. Was cese referred to medical examiner?		1-	26. Place of Death	n (Check only one	9)				
inis al dir	ပ		2 ER/Outpatie	III OLI DON			nce 6 Other (S	Specify)			
fler		27. Manner of Death 1 ★ Natural 5 Pending 28a. Date of Injury (Month, Day, Yea	(r) 28b. Time of Injury	Wor	rk?	28d. Describe how	w injury occurred				
To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (Sp.	At home, farm, st]Yes 2□No	28f. Location (Str. City or Town,	eet and Number or , State)	Rural Route Number,			
he Funeral pletely fille	Medical C	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my and manner stated.	mination and/or in	nvestigation, in my	opinion, death occur	red at the time, da	ate and place, and	due to the cause(s)			
/ D	M	29b. Signature and title of certifier Signature and title of certifier Suntan	20	29c. Licen:	5931	J 29	anuary	onth, Day, Year) 5th 2009			
1		30. Name and address of person who completed cause of death Day T St. Date filed (Month, Day, Year) 32. Registrar's S	(Item 23a) (Type) 2835	Smith,	Avenue S	vite 20	3 Bath	mora MD:			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 00033 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4, 2009 Year **Physician** Bernadette M. **Eckhart** January 12:43 pmM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Gilchrist Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 💢 F 85 Yrs 219-18-6724 Julu 11,1923 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Proficet Evar, her must be notified at once. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Baltimore Baltimore 1 ☐Yes 27 No Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21209 U.S.A. 2203 Falls Gable Lane, Unit G Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√No Specify Specify: White þ 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Rolfes Mary Jagielski ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12124 Buttonwood Lane, Middle River, MD Jmaes M. Wheeler 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Dulaney Valley Cem. 1/8/2009 Timonium, MD 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc
3631 Falls Road, Baltimore, MD 21211 21. Signature of Funeral Service Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Maxphar Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 9 gastointimo bleedin 2 No 3 Probably 4 Unknown page 2 should Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perform Physician: The certificate 1 ☐ Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) WOSPW 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Hospital or Attending 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 058303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G701 N. Charles ST Truson MD AMONT CHANCES MO 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Items 10a-f, 19b per inf g887 1-22-09 vt
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Ann **Eberhardt** Louise anuary 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 9. Birthplace (State or Foreign Ohio 7. Age (In yrs. last birthday) **Funeral** Social Security Number 1 □ M 2 🗓 F Months Days Hours Min. 377-44-4692 67 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at Florida Maryland Director Sarasota TAYes 2 No Sarasota - Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 34236-0000 Oe. Street and Number 1216 West Way Drive 1646 Roundhill Road 1 and 2 should be filed within 72 hours after death with 1 Health and Mental Hygiene. em 27 is marked other than "natural", or Items 23a or U.S.A. 21218 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐Yes 2 🕱 No Specify: Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Business Manager Consultant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ester Byers Robert Yolton ٩ 19a. Informant's Name/Relationship (Type. Print) 1911 18 Adwest Freehard Nobel of Bural System 1854 Fig. 1874 1874 1818 213 4236-0000 146 Roundhill Road Baltimore, Maryland 21218 Mr. David Peirick – Husband permit. Pages 1 and Department of Healt Important: If Item 27 any Injury or other i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Hilltop Service Corporation 01/05/2009 Towson, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lie 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the divise, or complications have caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart filtere. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** OVAKIAN /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or as a conse juence of Examine the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed has page 2 certificate 1 □Yes 2 No 1 TYes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one examiner? 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA မ 1 Inpatient After this Manner of eath Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation s after dea... 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funeral D 29a, Certifier CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature, and title of ce anuar 10/1/51 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hosrow Taba. 5601 Loch

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 0 5 200

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 20 for State Registrar 00035 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Co120A Donald Zhuz 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** -31/haven COM KOSVILLE 8. Date of Birth
June 5, 1927 6. Sex 1 Year / If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1**X** M 2□ F Months Days Hours Min 572-20-2936 81 Director Usual Residence of Decedent 10c, City, Town or Location 10a. State 10h County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No MD Sykesville Director Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 7200 Third Avenue USA Completed by Funeral 12. Was Decedent Ever in U.S. Aymed Forces? 1≜1Yes 2 ☐ No If Yes, Give Year or Dates: WWI 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: WWII Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Professor of Botany Education alth and Mental Hygir 27 is marked other r traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bilpha Johnson Oscar Harrison Edinger, Jr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11504 Luvie Court, Potomac, MD 20854 Christine Cockrell (Executor) 20a. Method of Disposition
1 ☐ Burial 24 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of H Important: If Itel any injury or otl once. 4 ☐ Donation 5 ☐ Other (Specify) County Cremation 1/2/2009 Sykesville, MD 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** xew /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical the as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 🗌 Yes 2 No 2 Accident

Division or Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death

other

Health i

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the a certificate has b irector, page 2 s this After Director; / within 24 hours aft

To the Funeral DI

completely filled in

physician

6 □ Could not be 3☐ Suicide

29b. Signature and title of certifier

30. Name and address of cers

29a. Certifier

determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number

29d. Date signed (Month, Day, Year) 2009

10

State Registrar

Medical

31. Date filed (Month,

cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1 - For State Registral 00036 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year Physician Sylvester Ferrell, Jr. January 2, 2009 10:35 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice TOWSON Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
June 23, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days **¥C**KM 2□ F Hours 51 231-88-7440 Virginia Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show 10a. State If item 27 is marked other than "natural", or items 23a or 28a-f shot or other traumatic event, I'm I redical Eraci par must be published at 1 Yes 2 No Maryland Baltimore Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 1803 Woodbourne Avenue 21239 of America Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: Black δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) furniture h and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sylvester Ferrell, Sr. Lottie Battle ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any Injury or other trau Sheldia Jones/ wife 1803 Woodbourne Avenue Baltimore, Maryland 21239 20b. Place of Disposition (Name of Commenter) Comments of Other place) 20a. Method of Disposition 20c. Location - City or Town, State January 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Chapel- Bel Air 4 Donation 5 Dother (Specify) 3, 2009 Forest Hill, Maryland 21. Signature of Funeral Service Licensee Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complicate is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) IVER **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter tradition of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □Yes 2 in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 21/10 Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death
Natural
Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide lled 29a. Certifier etifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

10:35

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Sylvester

Hospital or Attending Physician: this within 24 hours after death. To the Funeral Director; A completely the

State Registrar

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

505W. MO 32. Regist ar's Signature

Baltimore, Maryland 21215-0036

the burial-transi attending physician and P.O. Box 68760, Records, page 2 should of Vital

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Donald Parr Fogle 2009 Januar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Days Yrs 212-14-7943 10, Director Mar. 1917 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 XYes 2 □ No Maryland Frederick Thurmont 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number ō 116 Water St. 21788 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 ☐ Never Married 2 🔀 Married 9 If Yes, Give Year or Dates: 1 ☐Yes 2 X No Specify: 2 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Heath and Mental Hygiene important: If item 27 is marked other than any injury or other fraumatic event, Item Magnes. Elementary/Secondary (0-12) College (1-4or 5+) heavy equipment operator 8 construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel C. Fogle Estelle Forney ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian A. Fogle/ wife 116 Water St. Thurmont, MD 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🔯 Burial 2 □ Cremation 3 □ Removal from State 1/6/2009 Rocky Hill Cemetery 4 Donation 5 Dother (Specify) nr. Woodsboro, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Licens Tatharine 404 S. Main St. Woodsboro, MD 21798 23a. Par 1. Enter the disease, or complications that cused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 820 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** hos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal deat 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe this certificate 2 1 No 2 🗆 No 1 ☐ Yes 1 ☐ Yes To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 PER/Outpatient 3 DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day, Year) 28b. Time of injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 □ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed caus of death (Item 23a) (Type, Print) SHAMAB ? 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1	Bo	attend for us	ian/			1 ☐Live b	irth 2 Feta	al déath 3						2		-		
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Div	after Direct	ertif	4 ☐ Homicide	determined				001, 1401019,	, omec		201. 6	ity or Town	n, State)	i Number of	nuiai i	noute ivarriber,	
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Physician /Medical **Examiner**

Funeral Director

To Be Completed by Funeral Director

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1 - For State Registrar	•	partment of Health and N Certificate of Death		2009	00039
1. Decedent's Name (First, Middle, Last)			2. Date of Death JANUARY 1	² 2009 ^{Year}	3. Time of Death
RITA C.	FRIEDBERG				5:55 P M
4a. Facility Name (If not institution, give st. MILFORD MANOR NUF	· ·	4b. City, Town, or Location of Death BALTIMORE	4	BALTIMOF	RE
5. Social Security Number 6. Sex 1 Usual Residence of Decedent	7. Age (In yrs. last birthd	Months Days Hours Min	8. Date of Birth 10/10/1915	y) 9. Birthp Coul	place (State or Foreign ntry) MD
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10e. Street and Number		10f. Zip Code	Citizen of What Country?		
4204 OLD MILFORD	MILL ROAD	21208	USA		
11. Marital Status 12 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give A Year or Dates:	3. Was Decedent of Hispanic Origin? (Sr If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☑ No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Americ Black, White, Specify: WH]	etc.
15. Decedent's Educa		ecedent's Usual Occupation	16b.	Kind of Business/In	
(Specify only highest grade of Elementary/Secondary (0-12)	completed) (G	ive kind of work done during most of work e. DO NOT use retired) HOMEMAKER	king	OWN HOME	,
17. Father's Name (First, Middle, Last)			e (First, Middle, Maide		
LOUIS	GOLDBERG	LILLIA	AN G	GOLDBERG	
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20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Rei 4 □ Donation 5 □ Other (Specify)	moval from State cemetery, o	crematory or other place)		Location - City or To	
21. Signature of Funeral Service Licensee	/	22. Name and Address of Facility SC 8900 REISTERSTOWN F	LEVINSON ROAD PIKES	l & BROS., SVILLE, MC	
23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the death. Do not cause on each line.	enter the mode of dying, such as cardiac tage. Denentin	or respiratory arrest,		Approximate Interval Between Oriset and Death UNUMM
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that initiated events c. resulting in death) Last	Due to (or as a consequence of):				
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive	ery Day Year
Part II. Other significant conditions contr	ributing to death but not resulting in the	e underlying cause given in Part I.		use contribute to the	he cause of death?
	O		24a. Was an autopsy performed?	24b. Were auto	ppsy findings available mpletion of cause of
OF Was seen referred to the first			1 □ Yes 2 🗗	No 1 ☐ Yes	2 🗆 No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Ho	espital:	Othor	th (Check only one)	о Пон -	
27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient 2 ☐ ER/Outpate 28a. Date of Injury (Month, Day, Year) 28b. Tim	e of 28c. Injury at	ome 5 Residence 28d. Describe how in		fy)
2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Street City or Town, Sta	and Number or Rura ite)	al Route Number,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3	□ DOA Other: 4 □ Nursing H	lome 5 ☐ Residence 6 ☐ Other (Specify)			
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred			
3 ☐ Suicide 6 ☐ Could not be determined		ctory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 Certifying Pr 2 Medical Exar	nysician: To the best of my knowledge, death occuminer: On the basis of examination and/or investigand manner stated.	rred at the time, date and place ation, in my opinion, death occu	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)			
29b. Signature and title of certifier	py	29c. License number /) 2 7 56 4	29d. Date signed (Month, Day, Year)			
30. Name and address of person who	completed cause of death (Item 23a) (Type, Print) Len Lettleman (S	35 Green	e Tree Pd 21208			

State Registrar 31. Date filed (Month, Day, Year)

JAN 0 5 2 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 00040 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death Day Year STANLEY FISHER January 2, 2009 8:45 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Towson If Under 1 Year Greater Baltimore Medical Center **Baltimore** 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. XXM 2 F 73 217-30-4841 01/11/1935 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 OLD COURT ROAD, #501 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? i√m Yes 2 □ No i Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify 4 Divorced Specify. 3 Widowed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working

Physician /Medical

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating to notified at once.

Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

10a. State

MD

Funeral Director

leted by

Funeral

Director

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tranbeen signed by the should be detached certificate has birector, page 2 sl

Division of Vital Records, P.O. Box 68760,

Be Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	SALES	· ·	10H	ME IMPRO	VEMENT	
e C	17. Father's Name (First, Middle, Last	')		18. Mother's Na	me (First, Middle, Maid	en Surname)		
To B	LOUIS	FISHER		SARAH	1	MAGED		
	19a. Informant's Name/Relationship	(Type. Print)	19b. Mailing Addres	s (Street and Number or F	Rural Route Number, Cit	y or Town, State,	Zip Code)	
	LONNIE FISHER / S	SON	1035 N. C	ALVERT STREE	T., #3B B/	ALTIMORE	, MD 21202	
	20a. Method of Disposition	20b. Pl	lace of Disposition (Na emetery, crematory or	me of other place)	Date 20c.	Location - City or	Town, State	
	1 XI Burial 2 □ Cremation 3 □ 4 □ Ornation 5 □ Other (Specia	Removal from State ARL	INGTON CHI	ZUK _{AMUNO} 01/	'05/2009 B	ALTIMORE	, MD	
	21 Jate of European Service L	Dugar		rd Address of Facility S	OL LEVINSON		., INC. MD 21208	
	23a. Part 1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. A OS IS		de of dying, such as cardia			Approximate Interval Between Onset and Death	
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Bould for as a consequence of the consequence of	functions				I week	
Exami	Cause (Disease or injury that initiated events resulting in death) Last	c. C. d. Ff. c.le Due to (or as a consequ	colitis		·			
l edica	•	d						
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ectopic	pregnancy pecify)		23d. Date of de Month	-	
ed by Pr	Part II. Other significant conditions of	contributing to death but not resu	lting in the underlying o	cause given in Part I.	23e. Did tobacco use contribute to the cause of de			
Complet					24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of	
Be	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)			
	1 ☐ Yes Ž ☐ No	Hospital: 1 Nppatient 2 1	ER/Outpatient 3 ☐ D	OA Other: 4 I Nursing I	Home 5 Residence	6 ☐ Other (Spe	ecify)	
Medical Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year) n	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inj	ury occurred		
Certific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, street, factor)	y, office	28f. Location (Street City or Town, Sta	and Number or R ite)	ural Route Number,	
edical	29a. Certifier (Check only one)	nysician: To the best of my know miner: On the basis of examinat and manner stated.	vledge, death occurred ion and/or investigation	at the time, date and place, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner a nd place, and du	s stated. e to the cause(s)	
Σ	29b. Signature and title of certifier		29	c. License number	29d. [ate signed (Mon	th, Day, Year)	
		than MD		D 20907	1/	2/09		
		itham 6	71-1 1/1	harles St	rect, Bol	tin one,	1921204	
e ır	31. Date filed (Month, Day, Year)	32. Registrar's Signati	A. facts	1			(

DHMH 17 Rev 1/2001

State Registrar

within 24 hours after death.

To the Funeral Director; A completely filled in by the fu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death William Month Arnold anuavy 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Loch Raven V.A. Rehabilitation Baltimore n/a If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye March 2, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign . 1929 Hours Min. Days Months 220-24-4939 1 M 2 □ F 79 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Timonium 1 ☐Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 Stapleton Court Unit 101 21093 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, 1 ⊠Yes 2 No If Yes, Give 151 - 152 Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: uhite 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Installation Telephone 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fay, Jr. Charles Catherine Margaret Kelly George 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Stapleton Ct., Unit 101 Timonium, MD 21093 Virginia M. Fay-wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View 01/07/09 Sykesville, MD 21. Signature of Funeral Servicensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LSease Due to (or as a consequence of): state ancev Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ancer Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Duknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Renabilitation Hospital: 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 W Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

The law requires that the death certificate be executed g physician and is the burial-tran Box 68760, attending p for use as 1 o been signed by the should be detached ٣. of Vital Records,

after death.

Director: After this certification by the funeral director.

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/Medical

Examiner

Funeral

Director

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Physician/Medical

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ical Certification: To

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permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Important: If item 27 is marked other I any Injury or other traumatic event, In

Physician /Medical

Examiner

within 72 hours after

Baltimore, Maryland 21215-0036

or Attending Physician: Division Hospital e Funeral I within 2 To the

State

Registrar

completely filled

29b. Signature and title of certifier

3 Suicide

29a, Certifier

4 ☐ Homicide

6 □ Could not be

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) January 2, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Mame and address of person who completed cause of death Nitem 23a) (Type, Print)
(De Ovge E. Wicks M. M. . 3900 Loch Raven Boulevard, Baltimore,

31. Date filed (Month, Day, Year) JAN 0 5 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 2340 p M Evelvn May Gilbert 2009 4b. City, Town, or Location of Death 4c. County of Death Baltimore Center 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🖵 F 68 Yrs. June 16,1940 Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Middle River 10f. Zip Code 10g. Citizen of What Country?

Approximate Interval Between Onset and Death

Day

Year

/Medical 4a. Facility Name (If not institution, give street and number) Examiner FRANKLIN SQUARE HOSPITAL 5. Social Security Number **Funeral** 556 56 3532 Director Usual Residence of Decedent with the Maryland 10a State 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shot Injury or other traumatic event, the Medical Examble must be notified at Director Maryland Baltimore 10e. Street and Number 205 Glider Drive 21220 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White <u>چ</u> 3 XWidowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Data Processor Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be 1 nent of Health and Mental John Oliver Weir Virginia Russo and N 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trau once. Rebecca Nelson (daughter) 205 Glider Drive Middle River Maryland 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. Jan 7 2009 Baltimore County Md 4 ☐ conation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Lie 22. Name and Address of Facility Bruz zinski Funeral Home PA ▶ 1407 Old Eastern Avenue Essex MAryland 21221 23a. Part Effet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immedia Cause (Final **Physician** Septic Shock Due o (or as a consequence of): disease or condition resulting in death) /Medical Examiner Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physiclan and s the burial-trans Failure Renal Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical O.P.D attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ੬ Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has lirector, page 2 s has performe 1 □Yes 2 🗹 No ours after death.

eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) RES0000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN Balto md SAFAL Shetty Sauare DR

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year) -

JAN 0 6 2009

Physician

parke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10 A. Gardner 3, /Medical Eleanor P. Ian. 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster 325 Beaver Run Ct 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) May 24, 1932 Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Months Days Hours Min 1 ☐ M 2 💢 F 76 212-30-6878 Director Reisterstown, Md Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or higher transmit be not in all any or other traumatic event, he Medical Exprints in all be not lined at uny or other traumatic event, he Medical Exprints in all be not lined at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f shov Examinar must be notified at 1 □Yes No Director Westminster Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 USA Funeral 325 Beaver Run 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 ¬No þ 3 ☐ Widowed 4 ☐ Divorced Specify: Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Church 12 Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be I. Clyde Palmer Bessie Uhler 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trauonce. Douglas A. Gardner Son 2313 Sandel Lane, Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All Saints' Cemetery: 1/7/09 Reisterstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, Md. 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 100 Wald Minutes ase or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): il or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending newskings and y physician and is the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760, attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by re35 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an cate has by page 2 sl autopsy performe 1 ☐Yes 2 🗷 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann of Death funeral 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

buni- Acelmo



Sporer De

Svite

29c. License number

100059943

29d. Date signed (Month, Day, Year)

5,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. per FH G887 1/08/09 JH
State of Maryland / Department of Health and Mental Hygiene amend #20b per Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician ANUAR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore Nursing If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 8, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F Months Mary Land 215-34-6436 74 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location or items 23a or 28a-f show 10d. Inside City Limits Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, It is involved. Evaning must be notified at once. 1 ☐ Yes 2 No **Funeral Director** MD Baltimore Lansdowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2506 Gehb Avenue 21227 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent Ever in U.S. Was Deces? Armed Forces? ¹ □Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No If Yes, Give Year or Dates: Specify White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) $\overset{\text{Elementary/Secondary (0-12)}}{12}$ College (1-4or 5+) Clerk Insurance 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Anthony Glorioso, Sr. Providenza Hilda Battaglia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Patti - Niece 2502 Gheb Avenue, Halethorpe, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Cathedral Cemetery 1-6-2009 1X Bunial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 4 ☐ Donation, 5 ☐ Other (Specify) 22 Name and Address of Facility Ambrose Funeral Home, Inc. Signature 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part 1 Inter the disease, or complications that caused the death slock, or heart failure. List only one cause on each line. do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final eumonia Physician disease or condition resulting in death) Week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed y physician and is the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 W 1 ☐ Yes 2 🔭 No 3 Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No cate has by page 2 s certificate ement 1 □ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation after death.

I Director: Af in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a

To the Funeral (
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ü enson 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

			For State	State	of Marylan	•	artment of h		Mental Hy	_	000	0.0	01 =
			Registrar 1. Decedent's Name (First, Middle.	(act)			uncate of	Dealii	2. Date of De	Reg. No.	009	3. Time of	U45
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	/Medic		Mary F. Grogg 4a. Facility Name (If not institution,	aive street and no	ımber)		4b. City, Town, c	r Location of Dea			unty of Death	7.05	А
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	ns 20	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13. \	Was Decedent of H		Specify Yes or N		Race - Americ	an Indian,	
٥	after o		1 ☐ Never Married 2 ☐ Marri	Armed F 1 Tes If Yes, G	2 📉 No		f Yes, specify Cub 1 □ Yes 2 🛚 No		rto Rican, etc.)		Black, White,		
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ה	72 h "natu	ete	15. Decedent' (Specify only highes	s Education t grade completed,)	16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation during most of w	orking	16b. Kind	of Business/In	dustry	
21215-0036	within ene. than	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)		omemaker	a)		Own	Home		
D D	filed Hygi other		17. Father's Name (First, Middle, I	.ast)				18. Mother's Na	ame (First, Middle				
/land	ld be fental ked c	To Be	Arthur G. Rup					Lena	R. Urps				
ar S	shou and M s mar umat	-	19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Mailir	ng Address (Street	and Number or I	Rural Route Numi	oer, City or To	own, State, Zip	Code)	
, Ma	and 2 salth a r 27 is er tra		Robyn H. Blood	good/Gran	ddaughter	4017	Tranqui:	lity Cou	rt, Monr	ovia,	Maryla	nd 21	.770
ore,	es 1.8		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	2 Demoval from	20b. I	Place of Dispo cemetery, crer	sition (Name of natory or other pla	ce) Tom	Date ary 6,	20c. Locat	tion - City or To	wn, State	
altimor	Pag ment ant: I ury o		4 □ Donation 5 □ Other (Sp				emorial Pa	rk 200	9		ville,		and
Dall	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menlar Hygiene. I Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be notified at once.		21. Signature of Funeral Service L	icensee	M011	173 K	Name and Address obert A. F 00 W. Mont	ess of Facility Comphrey Fundamenty Av	uneral Hon enue, Rock	e, Rock wille,	ville, I Maryland	Inc. 1 20850	
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d.	/Medical		resulting in death)	a.	(or as a conseq	uence of):							
	Examiner	ایا	Sequentially list conditions,	D	ostridiu (or as a conseq		icile						
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7.	hat the sid by detacl		Part II. Other significant conditio	ns contributing to	death but not res	sulting in the u	nderlying cause gi	ven in Part I.	23e. Did	tobacco use	contribute to t	he cause of	death?
as,	Attending Physician: The law requires that the death certific are death a fact at a fact. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	d by				Ü	, , ,		1 🗆	Yes 2□1	No 3□ Pro	oably 4∭	Unknown
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	Physiclan: r this certific ral director,	To B	examiner? 1 Yes 2 No	Hospital: 12	Inpatient 2	ER/Outpatier	nt 3 DOA Oti	ner: 4 🗆 Nursing	Home 5 ☐ Res	idence 6	Other (Speci	fy)	
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	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funeral			g Physician: To the Examiner: On the									s)
	thin 2,	Medical	29b. Signature and title of certifier	and ma	nner stated.		29c. Licen	se number		29d. Date s	signed (Month,	Day, Year)	
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	/		30. Name and address of person v	who completed car	use of death (Ites	m 23a) (Type	Print)						
	2		Brian Carpent				Center	Drive, R	lockville	, Mary	yland	20850	
	Sta		31. Date filed (Month, Day, Year)	32.	Registrar's Signa	ature							
	Registr	ar	JAN 06	2009 🗷	news ,	A. And	Made						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND, TTEM#9perFH, G887, 1/5/09 WS State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 446 PM Irene. Griakarmakis JAMI JAM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAMVIEWINEDICAL CENTER BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Dec. 7 1 9. Birthplace (State or Foreign Country Greece 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex 1 M 2 F 1929 219-50-5184 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a State 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Maryland NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 408 South Macon Street 21224 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) Nikolitsis Fortene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21222 (Daughter) 1604 Four Georges Ct. Apt. A-4 Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State January 6, 2009 Oak Lawn Cemetery East Point, Maryland 22. Name and Address of Facility
W. Dabrowski/Chojnacki Funeral Homes P.A. wacker-1005 Dundalk Ave. Baltimore, Maryland 21224 his that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death CAMEBIAC ARRYTHMIA 30 minutes Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? CARDIOMY CPATILLY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar autopsy performed 1 ☐ Yes 2 ☐ No 1 □ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, this after death Director: 24 hours a Funeral D within 2.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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death with the Maryland

Baltimore, Maryland 21215-0036

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Experiment, and be retiffed at once. Completed 17. Father's Name (First, Middle, Last) Be ပ Nickolas 19a. Informant's Name/Relationship (Type. Print) Anna Fotopulos 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one complications are complicated as the complex of the co Immediate Cause (Final disease or condition resulting in death) /Medical Sequentially list conditions, if any, leading to immediate cause. Lines Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-tran Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 page 2 should Completed 25. Was case referred to medical Be examiner 1 Yes 2 No Certification: To 27, Manner of Death 1 Natural 2 Accident 3 Suicide filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) RES- 000 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 MD 2/224 M. D Baltimore Eastern Avenue 31. Date filed (Month, Day, -Year) 32. Registrar's Signature State Registrar JAN 0 5 2009

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2, 2009 Ye ar Day Elizabeth Pearl Gallaway B:25 p ^M January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan 9, 1920 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F Months Days Hours Min 220-09-8887 88 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Exercitors must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Southerly Road #313 21286 death v Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2X No Specify Specify: Lhite Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Office Worker Credit Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental **william** Frederick Haas Florence ဥ Pearl Herrington 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tr Thomas Renner-attornev 502 washington Ave, Suite 700, Towson, MD 21204 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Hilltop Serv Corp 01/06/09 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servicensee william G. 22. Name and Address of FacilityRuck Towson Funeral Home, Inc. Dau Mu 1050 York Rd. Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death OVAR Immediate Cause (Final 1 AN Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury Examine Due to (or as a consequence of) that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Year Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate perform Vital 2 No 1 □ Yes 1 ☐ Yes Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Xother (Specify) HOSPICE Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA of this 28a. Date of Injury (Month, Day, Year) funeral ne Hospital or Attending Pt n 24 hours after death. te Funeral Director; After th 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No filled in by the Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2. 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day,

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555W.

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	State Registrar		(Certificate of	Death	Reg	.n2009	00048
	Physicia	an	1. Decedent's Name (First, Middle, Last					2. Date of Death Month JANUARY	Day 01,2009	3. Time of Death 2.4 : 224 M
	/Medic	al	Lawrence 4a. Facility Name (If not institution, give		bowski	4h City Town o	r Location of Death		4c. County of Deat	
and the same	Examin		Saint Joseph	Medical (Towso	n	Balt	imore
	Funeral Director		000 00 0707	X M 2□ F 7. Age	(In yrs. last birth	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Sept 8, 1	919 Mic	hplace (State or Foreign unity) Chigan
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location	-			10d. Inside City Limits
	Maryl -f sho	ţ	MD Baltim	ore	T	owson				1 □Yes 2 🔀 No
	or 28a	Director	10e. Street and Number		 	10f. Zip Code		10g	. Citizen of What Co	untry?
	23a c	ra [1017 Timber Trai	l Road		212			U.S.A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Ever item is just be indifficed at once.	by Funeral I	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 □Yes 2 □ No If Yes, Give Year or Dates 1		13. Was Decedent of Head of the lif Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
9	2 hou	ted	15. Decedent's Edi	ucation	16a. I	Decedent's Usual Occup	oation		b. Kind of Business/	Industry
21215	d within 7; giene. er than "n	Completed	(Specify only highest grade	College (1-4or 5+	Dir	Give kind of work done life. DO NOT use retire ECTOT OF PI ounting	operty	ing	Rail Road	i
Maryland 21215-0036	uld be file Mental Hy irked othe	To Be (17. Father's Name (First, Middle, Last)	Grabowsk	i		18. Mother's Nam	e (First, Middle, Ma		tten
, Mar	and 2 sho salth and i 27 is me er traume		19a. Informant's Name/Relationship (7 Hilda P. Grabowsk		10	Mailing Address (Street 17 Timber T	rail Rd.,			_
altimore,	Pages 1 ann of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			Disposition (Name of c, crematory or other pla p Serv Corp		_ / _	oc. Location - City or Towson,MD	
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			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused	the death. Do no	ot enter the mode of dyi	ng, such as cardiac	or respiratory arres	t,	Approximate Interval Between
alan.	Physician	2 0	Immediate Cause (Final disease or condition			DIAL INFA	RCTION			Onset and Death
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	Lxammer	<u></u>	Sequentially list conditions,	h	e to (or as a consequence of):					
J	uted 1 insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 10 (01 as a	oonsequence of	.,,				
68760, <	be exectician and purial-tra	al Exa	that initiated events resulting in death) Last	Due to (or as a	consequence of	f):				
687	ificate g phys	Medical		d						
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burfal-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 24 Pregnant at 9 Unknown	2 🗌 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	cy		23d. Date of de Month	livery Day Year
ds, P.	uires that t signed by d be detac	þ	Part II. Other significant conditions of	ontributing to death bu	t not resulting in	the underlying cause gi	ven in Part I.		,	o the cause of death?
CO	w requir s been s should	lete						24a. Was an	24b. Were ar	utopsy findings available
I Re	hysiclan: The law his certificate has I director, page 2 8	Completed						autopsy performe 1 □ Yes 2	prior to death?	completion of cause of
Vita	Physiclan: r this certific ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		Ott	ner.	th (Check only one)		
of	Phys r this ral dir	<u>ا:</u>	1 Yes 2 No 27. Manner of Death	1 Inpatie		patient 3 DOA	4 Li Nursing n	ome 5 Residen 28d. Describe how	ce 6 Other (Spe	ecify)
o	Attending r death. ector: After by the fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day		ijury Wo	rkí?]Yes 2. □No			
Division of Vital Records,	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification: To	3 Suicide 6 Could not be 4 Homicide determined		ry - At home, fari . (Specify)	m, street, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Directory completely filled in by	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of the basis of and manner sta	examination and	death occurred at the td/or investigation, in my	time, date and place opinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner a e and place, and du	s stated. e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	On an A		29c. Licen	se number		d. Date signed (Moni	
			A. U. He	lou, M. D	-	Da017695 January 1, 2009				
,	10X1		30. Name and address of person who	completed cause of de						
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		ARDALIAH J. HE 31. Date filed (Month, Day, Year)	* Registra	r's Signature	OSLER DR	IVE TOWS	SON, MAR	YLAND :	21204
	Sta Registi		IAND 5 2000	12 Dec	1. 4	arked				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 955 PM **Physician** Janyary Shirley A. Hyatt 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore n/a If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month. Day 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Min 9/24/1932 1 □ M 2 🛛 F 76 Virginia 216-28-2681 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedford Examinations to rother traumatic event, the Wedford Examinations to rother death of the profiled at any injury or other traumatic event, the Wedford Examinations and once. 1 Yes 2 No Director MD n/a Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21230 USA 2441 Harriet Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Spencer Ore Orpha McCov ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2441 Harriet Avenue, Baltimore, Maryland 21230 Dale T. Hyatt / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1/5/2009 Bayview Crematory Baltimore, Maryland 5 ☐ Other (Specify) 4 ☐ Donation 22. Name and Address of Facility 21. gnature Funeral Service Licensee Hubbard Funeral Home, Inc. 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 2 weeks **Physician** vocardial disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner pertension Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Known or Attending Physician: The law requires that the death certificate be executed perlipidemi attending physician and for use as the burial-tran that initiated events resulting in death) Last Due (of or as a consequence of) Division of Vital Records, P.O. Box 68760, 5) IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown s been signed by should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed 1 □Yes 2 PNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death. investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD Cym 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Memorial Hospital, M.D. 31. Date filed (Month, Day,) nion Registrar's Signature Year) State 6 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Eileen Virginia Hutson Erwany /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 □ M 2 🖾 F 81 April 3,1927 Director PA 218-22-6173 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Inpopartment of Health and Mental Hyglene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, it is Medical Examiner must be notified at once. 1 Tyes 2 TXNo Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7728 Central Ave. Funeral 21122 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 2.X.Mo 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specifywhite \$ 3 Widowed 4 Divorced Baltimore, Maryland 21215-00 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th Homemaker Household 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Claude Watson Helen Mays ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Matthew E Hutson spouse 7728 Central Ave. Pasadena MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1/5,2009Glen Burnie MD 21. Signature of Funeral Service Line 22. Name and Address of Facility Stallings Funeral Home P.A. 3111 Mountain Road Pasadena MD 21122 23a. Part 1, Enter the disease, or comf li lations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Vostmille mone /Medical Due to (or as a conse uence of): Examiner MOMMON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examin the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes No been signed by the should be detached 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 □No 1 ☐ Yes this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral of Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: / d in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 92. Registrar's Sgnatur 31. Date filed (Month, Day, Year) State JAN 0 6 2009 Registrar

DHMH 17 Rev 1/2001

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eg. No. 2	U	U	7	U	U	U	5	

	1 - State Registrar	Certificate of Death	Reg. No. 2009 00031
	1. Decedent's Name (First, Middle, Last)		Date of Death Month Day Year
Physician /Medical	ROBGRT HYD	ock	JANUARY 44 2009 713 PM
xaminer	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	BALTIHORE WASHINGTON HEL		AA COUNTY
al		(In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 7 1 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
tor	Usual Residence of Decedent	71 Yrs.	MAY 26, 1937 PA
unotified at irector		10c. City, Town or Location	10d. Inside City Limits
Ď	Maryland Anne Arundel	Pasadena	1 ☐ Yes 2 ☑ No
Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	222 Oak Drive	21122	USA
Funeral	11. Marital Status 12. Was Decedent E		
	Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Yes 2 □ No If Yes, Give	1 ☐ Yes 2 ☐ No Specify:	
ğ	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	To tes 2 Million Openiny.	Specify: White
Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of worki life. DO NOT use retired)	16b. Kind of Business/Industry
ם	Elementary/Secondary (0-12) College (1-4or 5+	7	
ပိ	12 1	Manager	Shipping Company (First, Middle, Maiden Surname)
Be	17. Father's Name (First, Middle, Last)		
2	Michael S. Hydock	Margare 19b. Mailing Address (Street and Number or Rur.	
	19a. Informant's Name/Relationship (Type. Print) Anna Rita Hydock (spous	3	
	20a. Method of Disposition		Date 10 20c. Location - City or Town, State
	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State		10 Baltimore, Maryland
	4 □ Donation 5 □ Other (Specify) 21. Signature of Funded Survice Ligensee	2	DO9 Baltimore, Maryland tallings Funeral Home, P.A.
	21. Signature of this state of the state of		d, Pasadena, MD 21122
-	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line		
			CAC C T (S A) Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	consequence of):	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	Due to (or as a	consequence ory.	
ĕ	Sequentially list conditions, if any, heading to him solute cause. Enter Underlying Cause (Disease or injury	consequence-off;	
Examiner	that initiated events c.		
	resulting in death) Last . Due to (or as a	consequence of):	
<u>is</u>	d		
/Medical	IF FEMALE: 23c. If yes, outcome of	of avarages (
_		2 ☐ Fetal death 3 ☐ Ectopic pregnancy	23d. Date of delivery Month Day Year
Physicial	1 Yes 2 No 9 Unknown	S Country Carlot (Specify)	
	Part II. Other significant conditions contributing to death but	t not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
d by	CHRONIC OBSTRUCTI	NE MURG DREUZE	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown
ete			24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
Completed			performed? death?
e)	25. Was case referred to medical	26 Place of Deat	1 □ Yes 2 ⊡No 1 □ Yes 2 □ No n (Check only one)
o O	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatier	Othor	me 5 ☐ Residence 6 ☐ Other (Specify)
	27. Manner of Death 28a. Date of Injury	y 28b. Time of 28c. Injury at	28d. Describe how injury occurred
a:C	2 Accident investigation	M 1 Yes 2 No	
Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju		28f. Location (Street and Number or Rural Route Number, City or Town, State)
Cer			
Medical ((Check only 2 Medical Examiner: On the basis of	f my knowledge, death occurred at the time, date and place, examination and/or investigation, in my opinion, death occur	
1	one) and manner state	ted. 29c. License number	29d. Date signed (Month, Day, Year)
2	29b. Signature and title of certifier	4.4	JANUARY 5, 2009
		Tab (Anna COn) (Tana Brink)	
	30. Name and address of person who completed cause of de	eath (Item 23a) (Type, Print) 300 S, 900	OVERST. BACTIMORE
Α.	31. Date filed (Month, Day, Year) 32. Registra	de Signature	_
State strar	JAN 0 8 2009	A barket	
1/2001	JAN U B ZUUS / CERETA	1. 17	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 5 200°9 Gerald R. Hutchins Jan :00A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 8103 Bletzer Road Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1**X** M 2□ F 212-36-5376 68 1,1940 Oma Director April Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Experiment must be notified at Baltimore Dundalk MD 1 ☐ Yes 🌪 No Director 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 8103 Bletzer Road 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2**X** No Specify Specify: White ≥ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician Myers Co. 9th Pages 1 and 2 should be filed vent of Health and Mental Hygidient: If Item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William H. Hutchins Helen V. Ward ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and. Department of Health Important: If Item 27 any Injury or other tr. Emma J. Hutchins 8101 Bletzer Road Baltimore MD 21222 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 1/8/09 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licensee. atrich Connelly Funeral Home of Essex 21221 K 23a. Part 1. Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner hyperlense Severe pulm Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed antre Stew and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown autonome displunctor Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 🗆 No 2 No 1 □Yes 1 ☐ Yes Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 D/No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manual of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation l or Attend after death Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 ☐ Homicide within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10-28097 1/6/09 Nonaed attacasio MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9114 Philadelphia Sunty 108 Balt, Md. 21237 ATTANASIO 31. Date filed (Month, Day, Year) egistrar's Signature State 6 Registrar

DHMH 17 Rev 1/2001

			_ State	tate of Maryland		rtment of H tificate of D			ene g. No. 2 N N Q	00053
			Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia /Medic		Walter T. Harris					January	4, 2009 Year	5:27 A M
7	Examin		4a. Facility Name (If not institution, give stre Gilchrist Hospice	et and number)		4b. City, Town, or Towson	Location of Death		4c. County of Death Baltimo	re
	Funeral Director		5. Social Security Number 6. Sex 1XX	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 30	9. Birth Cou 0, 1919 Mar	place (State or Foreign ntry) yland
	מ		Usual Residence of Decedent							10d, Inside City Limits
	shov	or	10a. State 10b. County N/A		Town or Loc Baltiı					XXYes 2 □ No
	the N	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?
	h with	al D	4111 Falls Road			21211			USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventual institutional and once.	by Funeral	1 ☐ Never Married 2 ☐ Married	Was Decedent Ever in U.S. Armed Forces? 1XX es 2 ☐ No If Yes, Give Year or Dates: WWII		Vas Decedent of Hispanic Origin? (Specify Yes or I Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes Wo Specify:		ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.
2-0	72 ho 'natur	eted	15. Decedent's Educati (Specify only highest grade co		(Give	lent's Usual Occupa kind of work done o	luring most of workii	ng 1	6b. Kind of Business/Ir	dustry
12	within ene. than'	Completed	Elementary/Secondary (0-12) Unknown	College (1-4or 5+)	Painte	00 NOT use retired _. er)	Г	Oomestic Pa	inting
d 2	Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M.	aiden Surname)	
/lan	uld be Menta Irked Irked	To B	Samuel Harris				Earla	Horning		
Maryland	2 sho and l	Ħ	19a. Informant's Name/Relationship (Type.	_ ′	19b. Mailin				City or Town, State, Zi	
	1 and Health em 27 Ither t	3	Darrell Harris S 20a. Method of Disposition	Son 20b. Plac	ce of Dispos	sition (Name of	, D		ce, Marylan Oc. Location - City or T	
Baltimore,	Pages tment of tant: If it		Marial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	cen	netery, cren yland	veterans Veterans	1/12/	2009 Ga	rrison For	est, MD
Bai	permit Depar Impor any In once.	(i)	21. Signatury of Funeral Service Licensee	lens		3631 Fal	ls Road,	Baltimor	al Home, In ce, Marylan	c. 21211 d
			23a. Part1. Enter the disease, or complicate shock, or reart failure. List only one of	ions that caused the death. cause on each line.	Do not ente	er the mode of dyin	g, such as cardiac o	or respiratory arre	st,	Approximate Interval Between Onset and Death
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			c cardi	o-Vascu	lande	secre	years.
1	Examiner			Due to (or as a conseque	nce of):					U
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ord	w require been si should b	ted	Certilovasa	eac asa	ے دو	•		1 ☐ Yes	s 2 □ No 3 2 Pro	babiy 4 🗆 Unknown
Vital Records,	Physician: The law in this certificate has bural director, page 2 sh	Completed						24a. Was an autopsy perform	prior to c	opsy findings available ompletion of cause of 2 □ No
/ita	cian: sertific sctor,	Be	25. Was case referred to medical examiner?	nital		Oth	26. Place of Death)	Interes Dieses
of	Physic rthis ral dire	7: 10	T Tes 212100	pital: 1 ☐ Inpatient 2 ☐ EF 28a. Date of Injury 2	R/Outpatier 8b. Time of		4 LI Nursing Ho	me 5 Resider		ity) HOSPICE
o	nding Ph th. : After th s funeral	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	Work	Yes 2 □ No	-00. 50001150110		
Division of	or Attendated after death	Certification:	- Cauld not be	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Rui State)	al Route Number,
_	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medical C		ian: To the best of my knowl r: On the basis of examinatio and manner stated.						
	To the within To the Comple	Me	29b. Signature and title of certifier	0 -		29c. Licens	e number	29	d. Date signed (Month	Day, Year)
			Frendall	(Vall	lu	D 8	2564	S	01/04/	2009
	311		30. Name and address of person who comp	oleted cause of death (Item 2	23a) (Type,	J. Tows	antown	Bud)	Bacton	D 21204
	Sta Registr		31. Date filed (Month Day, Year) 2009	32 Registra's Signatur	T. Asi	ukal		/		•
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2, 2009 Troy Lester Hash January 2:15 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Year 1 X M 2 □ F 94 Yrs 225-28-6860 Sept. 1914 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Maryland Montgomery Poolesville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 17028 Spates Hill Road 20837 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 No Specify White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0wner 8 Landscaping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Emmett Hash Edna Halsey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen B. Garner/Daughter 17028 Spates Hill Road, Poolesville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State January 9, 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2009 Rockville, Maryland Parklawn Memorial Park 21. Signature of Funeral Service Licensee 22, Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc. William a. Knowher M01173 300 W. Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multiple Myeloma Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy 2 X No 1 ☐ Yes 25. Was case referred to medical examiner?

Physician /Medical Examiner

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 is marked oth any injury or other traumatic event once.

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

ed other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at

hours after

filed withir I Hygiene.

Baltimore, Maryland 21215-0036

/Medical

10a. State

Examiner Physician/Medical

physician and s the burial-transit attending p for use as t ned by the signed by t has page certificate funeral director. After this

The law requires that the death certificate be executed

Physician:

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To the Hospital within 24 hours a To the Funeral C

Box 68760,

of Vital Records, P.O.

Division or Attending

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Be Completed

Certification: To

Medical

29a. Certifier

(Check only one)

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one) Hospital: Other: 4 In Nursing Home 5 In Residence 6 Nother (Specify) Hospice 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide

28b. Time of 28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

29b. Signature and title of certifier

29c. License number D0064615

29d. Date signed (Month, Day, Year) January 2, 2009

and address of person who completed cause of death (Item 23a) (Type, Print)

Genevieve Wroblewski, M.D. 6001 Muncaster Mill Road, Rockville, MD 20855

State Registra

completely

31. Date filed (Month, Day, Year) 0 6 2009

32. Registrar's Signature Barks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 1, 2009 2009 **Physician** Ruth Ellen Hutchinson 10:56 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Dec 11, 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Virginia Days 1□M 2X F 1924 Director 214-42-6857 Usual Residence of Decedent 10c. City. Town or Location 1∩a State 10b. County 10d. Inside City Limits at Examiner must be notifled 1 ☐ Yes 2 ☑ No Director MD St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 21412 Great Mills Rd. 20653 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify Specify: White 3 Widowed 4 Divorced Year or Dates: other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cook Research Lab 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I John Thomas Hale Hattie Winfield Harrison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6636 Washington Blvd. #81 Elkridge, MD 21075 Ruth F. Carmichael/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State W. Arundel Crematory 01/05/09 Odenton, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 21. Signatura MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) aspiration Physician TNEUM ONIA 10 minutes Medical Due to or as a consequence of): Examiner Due to (or as a consequence of): acute Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Archythmia ed by the attending physician and detached for use as the burial-trans CARDIAC Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

Or the Funeral Director: After this certificate has t completely filled in by the funeral director, page 2 s autopsy 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ို 1 Inpatient 2 ER/Outpatient 3 □ DOA 27. Manne of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certific 29d. Date signed (Month. Dav. Year)

To the Ho

utchinson

Ellen

State Registrar

DHMH 17 Rev 1/2001

Jerey D Tuke, Do 31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ret	or State			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Death	2	Reg. N . Date of Death		3. Time of Death
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Examiner 4a	. Facility Name (if not i	institution, give stre	et and number)	4	b. City, Town, or Locat Woodlawn	ion of Death		4c. County of D Baltimore	
.*	North Rolling Ro	oad/ East of S	ecurity Blvd. 7. Age (In yrs. las	at birthdav)	If Under 1 Year If I	Under 24Hrs.	8. Date of Birth(N	IM/DD/YYYY)	9. Birthplace (State or Foreign
	Social Security Number 218-84-828		1	Yrs	Months Days H	lours Min.	August 5	, 1975	Country) MD
	sual Residence of Dec	cedent		Town or Locat	ion				10d. Inside City Limits
au au 10		County Carro		TOWIT OF LOCAL	Sykesvill	e			1 Yes 2X No
permit. Pages 1 and 2 should be filed within 72 hours after death with the waxyons bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Important: If one Completed by Funeral Director	0e. Street and Number 7002 Bris	r			10f. Zip Code 21784			Citizen of Wha	USA
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or items 23 must be no Funeral	1 Never Married	2 X Married	Armed Forces? Yes 2 X No	1	Yes 2 X No sp			Specify:	White
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			1 - For State Of Ma	aryiana / Depa <i>Cer</i>	tificate of		R	eg. N 2009	00057
	Physicia	m	1. Decedent's Name (First, Middle, Last)				2. Date of Dear	Day Voor	3. Time of Death 5:45 P M
•	/Medic	al	James Leo Hirsch, Sr. 4a. Facility Name (If not institution, give street and number)		4h City Town o	r Location of Death	January	4c. County of Dea	
	Examin	er	103 wiltshire Lane		Severna			Anne Arun	
	Funeral Director			e (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept. 2	9. Bir 5,1927 Ma:	thplace (State or Foreign ountry) ryland
	pu 🛾		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits
	Maryla Fishor	tor	MD Anne Arundel	Severna Pa					1 □Yes 2\No
	th the)irec	10e. Street and Number		10f. Zip Code	<u> </u>	1	0g. Citizen of What Co	puntry?
	ath wil	ral	103 Wiltshire Lane		21146			USA	
_	Items	Funeral Director	11. Marital Status 12. Was Decedent If Armed Forces? 1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ N	Ever in U.S. 13. V		Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, Whit	
0000	urs af	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ N 3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes, Give Year or Dates:	wwII	□Yes 2 No	Specify:		Specify: Lh:	ite
<u>.</u>	72 ho	letec	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occup kind of work done	pation during most of work d)	king	16b. Kind of Business Copper & Br	,
7	within iene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5	+) Manag		a)		opper a br	Industry
yland z	2 should be filed within 72 hours after death with the Maryland a nard Memlar Hygiene. I a marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Evan account to a milling a	Be	17. Father's Name (First, Middle, Last) Joseph Hirsch			18. Mother's Nam Pauline	e (First, Middle, I e Dietz	Maiden Surname)	
Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inmoortant: If time 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Wedical Evan mere ust be mailined at once.	<u>٥</u>	19a. Informant's Name/Relationship (Type. Print) James L. Hirsch/ Son		g Address (Street			r, City or Town, State, . e, MD 2109	
ע	es 1 ar of Heg fitem r othe		20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State	20b. Place of Dispos cemetery, cren	sition (Name of natory or other place	ce)		20c. Location - City or	
	t. Pages thent of tant: If ite		4 ☐ Donation 5 ☐ Other (Specify)	Hilltop Se			1	Towson. Ma aryland 21:	ryland
D D	permit. Departr Importa any Inji		21. Signature of Funeral Service Licensee		Name and Addre			Inc. 1050	
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	ie.				est,	Approximate Interval Between Onset and Death
1"	Physician /Medical		Immediate Cause (Final disease or condition a a		yvoid	cancel	^		GMOS.
, zd	Examiner		Due to (or as	a consequence of):	~1				•
-	p #	ner	Sequentially list conditions, if any, leading to immediate causes. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as: c	a consequence of):					
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00/00	te be e ysician e buria	edical Examiner	d						
0	ertifica ing ph		IF FEMALE:						
. DOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 thours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	23c. If yes, outcome	2 ☐ Fetal death 3 ☐	Ectopic pregnand Other (specify) _	су		23d. Date of de Month	livery Day Year
Ľ	that the		Part II. Other significant conditions contributing to death be	ut not resulting in the un	nderlying cause giv	ven in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
ecords,	quires en sigr uld be	ed by		<u> </u>			1 □ Ye	es 2 <mark>8</mark> No 3□P	robably 4 🗆 Unknown
Dec.	he law re e has ber age 2 sho	Completed		-1-			24a. Was a autops perform	sy prior to med? death?	utopsy findings available completion of cause of
וומו	lan; T	Be C	25. Was case referred to medical			26. Place of Deat	1 □ Yes th (Check only on	4)	3 2 □ No
> · 5 i	hysic this ce al direc	ဥ	examiner? 1 ☐ Yes 2 SNo Hospital: 1 ☐ Inpatie			4 LI Nursing n	$-\Delta$	ence 6 ☐ Other (Spe	ecify)
	ding P h. After 1 funera	tion:	27. Manner of Death 1 Natural 5 Pending (Month, Day 2 Accident investigation	ry 28b. Time of Injury	28c. Injui Wor M 1 □	ryat k?]Yes 2 □ No	28d. Describe ho	ow injury occurred	
HOISINI	l or Atten after deat Director: I in by the	Certification:	2 Accident	ury - At home, farm, stre			28f. Location (St City or Town	treet and Number or R n, State)	ural Route Number,
	Hospita 24 hours Funeral etely filled	Medical C	29a. Certifier (Check only one) 1 CertifyIng Physician: To the best on the basis of and manner start.	f examination and/or in	n occurred at the ti vestigation, in my o	ime, date and place opinion, death occu	, and due to the c rred at the time, d	ause(s) and manner a late and place, and due	s stated. e to the cause(s)
	To the within To the compl.	Me	29b. Signature and title of certifier	_	29c. Licens	se number	2	9d. Date signed (Mont	h, Day, Year)
Ì	(K)		1 Jewany	~	LU	14838		1/2/20	09
	5		30. Name and address of person who completed cause of d Stravt E. Selonicu	1, Wo	900 B	sestgate	Rd. 1	Innapol	is, Urd.
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registra	ar's Signature	4.0				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2009 Year Altha May Jackson Рм January 2, 9:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Center Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🛭 F Months Pennsylvania 217 20 4200 85 Director Feb.6, 1923 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Marified Examiner must be rediffed at once. 1 ☐ Yes 2 No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1515 Barkley Avenue 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No \$ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cashier Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Llwelyn Lytle Winifred Kasiah May 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn E. Jackson (Son) 8188 Poinsett Terrace Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Gardens Of Faith Cem. 1/6/2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 21. Signature of Funeral Service Licenses onn 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** BREAST CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-tran Due to (or as a consequence of): To the Hospital or Attending Priysrcian. within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) ☐Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 □Yes 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hosnital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\mathbb{X} \) Other (Specify) \(\mathbb{HOSPICE} \) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

X Nurse Practitioner 29a Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

10

Baltimore, Maryland 21215-0036

of Vital Records, P.O. Box 68760,

ALTHA JACKSON

JANUARY

State Registrar Jackie Jones, CRNP 2300 Dulaney Valley Rd.

31. Date filed (Month, Day, Year) 32. Reciskar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AN 0 6 2009 Janua S. Jank

Timonium, MD 21093

			For State Registrar		State of M	larylan	d / Depa	artmer rtifica	nt of H te of L	lealth and D <i>eath</i>	Mental Hy	/giene Reg. No.		0005
	Physici	an	1. Decedent's Name (F	_	_{Last)} Jones						2. Date of De Month		^y 2009 ^{Year}	3. Time of Deat 8:00p
>	/Medic Examin		4a. Facility Name (If no	ot institution,	give street and numbe			1	Town, or	Location of Dea			County of Dea Balti	th
	Funeral Director		5. Social Security Number 281–16–0775	5	5. Sex 7. A 1 □ M 2 1 F	95 (In yrs. I	ast birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 24 Hr Hours Mir		ay, Year)	9. Bir	thplace (State or For ountry) OH
	Maryland a-f show	ctor	Usual Residence of De 10a. State 10 MD	Db. County Balti	more	10c. City	y, Town or Lo		lmoni	.um				10d. Inside City Lin 1 □Yes 2 🔀
	h with the 23a or 28 st be not	Funeral Director	10e. Street and Number 2300 Dular		11ey Road				p Code 21093	3		10g. Cit	USA	ountry?
980	be filed within 72 hours after death with the Maryland ntal Hygliene. ed other than "natural", or items 23a or 28a-f show event, the Medical Exeminer must be notified at	þ	11. Marital Status 1 □ Never Married → WWwidowed 4 □		12. Was Deceder Armed Forces d 1 □Yes 2 If Yes, Give Year or Dates	s?] No	S. 13.	Was Dece If Yes, spe 1 □ Yes	ecity Cuba	ispanic Origin? (n, Mexican, Pue Specify:	(Specify Yes or N erto Rican, etc.)	pecify Yes or No- o Rican, etc.) 14. Race - Americ Black, White, Specify: Wh		
Baltimore, Maryland 21215-0036	filed within 72 ho Hygiene. vther than "natur ent, Ine Medical	Completed			Education grade completed) College (1-40	r 5+)	16a. Dece (Give life.	kind of we DO NOT t	ual Occup ork done d ise retired emake	during most of w d)	orking	16b. Kind of Business/Industry Own Home		
land 2	should be filed nd Mental Hygi marked other ımatic event, I.	To Be C	17. Father's Name (Fir. William (st, Middle, La Crayto						18. Mother's Na Lola	ame (First, Middle, Maiden Surname) Knapp			
, Mary	. Pages 1 and 2 should b ment of Health and Ment ant: if Item 27 is marked lury or other traumatic e		19a. Informant's Name William Jo	e/Relationshi	y (Type. Print) Son			-	' .		Rural Route Numb Baltimo			
more,	Pages 1 and the control of Head int: if item iry or other		20a. Method of Dispos 1 X Burial 2 □ 0 4 □ Donation 5 [Cremation 3	3 ☑ Removal from State		lace of Displemetery, cre 'est G	matoryor	othar plac	ery 01/0	Date)8/09	Plain City, OH		
Balt	permit. Page Department of Important: If any injury or		21. Signature of Funer	ral Service Li	censeeDorota V. Uww.Su	Marsha Marsha					s Funera enue, Ba			
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the shock, or heart if shock, or heart if immediate Cause (Fir disease or condition resulting in death) Sequentially list condit if any, leading to immediate. Enter Underlyit Cause (Disease or injuthat initiated events	ailure. List o nal	b	ed the death line. YEVT us a consequence a	uence of):	ter the mo	de of dyir	ng, such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
8760,	icate be executed physician and the burial-transit	dical	that initiated events resulting in death) Las	t	c Due to (or a	as a consequ	uence of):							
0	ath certif attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pr in the past 12 mg 1 □ Yes 2 N 9 □ Unknown	onths?	23c. If yes, outcon 1 □ Live birth 4 □ Pregnan 9 □ Unknowr	n 2 ☐ Feta t at time of d	I death 3	□ Ectopic □ Other (s		у			23d. Date of de Month	elivery Day Year
rds, P.	quires that the de en signed by the a uld be detached is	þ	Part II. Other significa	ant condition	ns contributing to death	to death but not resulting in the underlying cause given in Part I.					1777		V	o the cause of death
of Vital Records,	r. The law requires that icate has been signed b ; page 2 should be deta	Completed									24a. Wa: auto perl 1 □Yes	s an opsy formed? 2 D No	prior to death?	utopsy findings availa completion of cause s 2 □No
Zit:	Physician: The this certificate ral director, pa) Be	25. Was case referred examiner? 1 ☐ Yes 2 No		Hospital:	utient 2□	EB/Outpatie	ent 3□□	Oth Oth		eath <i>(Check only</i> Home 5 Res		6 □Other (So	ecify)
on of	aling P. After fune	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga		28a. Date of li (Month, i		28b. Time of Injury		f 28c. Injury at Work?		28d. Describe			ocity)
Division	j ∰ j ∈	Certification:		3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home					ry, office		28f. Location City or To	(Street and Number or Rural Route Number, wn, State)		
	the Hospital hin 24 hours a the Funeral I npletely filled	Medical C		Medical E	Physician: To the be xaminer: On the basis SE PRACTITY	of examina						e, date an	d place, and du	e to the cause(s)
	To the To the Complex	M	29b. Signature and title	Me	SLANP	f dooth /lte-	n 23a\ /Tur-		R/9	9792	-	29d. Da	te signed (Mon	th, Day, Year)
_	1.		30. Name and address	afor berson w	nio completed cause o	. aeam (nen	. Loa) (Type	, i mily						

State Registrar JACKIE JONES, CRNP
31. Date filed (Month, Day, Year) JAN 0 6 2009

2300 DULANEY VALLEY ROAD

JANUARY 3,

State of Maryland / Department of Health and Mental Hygiene 00060 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2009 9:42 A M January Mary Regina Jones /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Frederick Northampton Manor Health Care Ctr. Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Mar. 2, 1 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Days Hours Min. 1 □ M 2 🕱 F Maryland 93 214-20-0417 Director Usual Besidence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Expanient and to a cultical at 1 XYes 2 No Director Frederick Frederick Maryland the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 21701 U.S.A. 1421 Taney Ave., Apt. 407 Funeral death 1 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) hospital nurse 10 and Mental Hygi 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elmer E. Smith Myrtle Green ည 19a. Informant's Name/Relationship (Type. Print) great 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Alisande Y. Brooks/ niece 13418 New Windsor Rd. Union Bridge, MD 21791 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State i i i Department of Important: If it any Injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Mem. Gardens 1/5/2009 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Licens attarine LIbertytown, MD 21762 11802 Liberty Rd. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** reels disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner rogressive if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consequence of): Examiner Due to (or as a g physician and or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Por 5 ☐ Other (specify) signed by the P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 **X** No 2 No 1 ☐ Yes 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation Natural after death.

I Director: Af din by the fur 1 □Yes 2 □No 2 ☐ Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral I

completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D43091 Tore House Auc. Porlanch 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 801 31. Date filed (Month, Day, 32. Registrar's Signature Year State JAN 0 5 2009 Registrar

Please Type or Print in	n Black Indelible Ink.	Ensure All Copies Are Legible
		- Itle and Mantal Hugiana

	1 - For State egistrar I. Decedent's Name (First, M		Certificate of Death	and Mental Hy	Reg. N		09 000 3. Time of Death
i il yololuli.			an		Month Da January 1, 20		2115 hrs
	4a. Facility Name (if not instit 259 Baskerville Co	ution, give street and number)	4b. City, To Severn	wn, or Location of Death a Park		4c. County of Deat Anne Arunde	
I dilicial	5. Social Security Number 358–56–1514	6. Sex 7. Age (In 1x M 2 F 51	yrs. last birthday) If Under Months		—	1M/DD/YYYY) 9. Bi Forei C	
ow any.	Usual Residence of Deceder 10a. State 10b. Cou MD Anne	nty 10c	Severna Park			, , , , , , , , , , , , , , , , , , , 	10d. Inside City Limits 1 Yes 2 No
he Maryland tor 28a-f sh	10e. Street and Number	rville Court	10f. Zip (10g.	Citizen of What Cor	untry?
2 hours after death with 1 "natural", or items 23s [Examiner must be not sted by Funeral	3 Widowed 4 X	Married 12. Was Decedent Eve Armed Forces? 1 Yes 2 X Divorced If Yes, Give Year or Dates: Specify only highest grade completed.	No If Yes, specify 1 Yes 2 ted) 16a. Decedent's Usual C during most of work	ing life. DO NOT use reti	work done 16	White, etc. Specify: Wh	s/Industry
[Fight 등 함] 전	12		Journeyma		e (First, Middle, Mai	Construc	tion
215-00 be filed with stall Hygien rked other ent, the M	17. Father's Name (First, Min Joseph P	_		Mary	D. Ga	aines	
212 hould be and Ment is mart rite ever	19a. Informant's Name/Rela	tionship (Type, Print)	19b. Mailing Address	(Street and Number or ville Court	Rural Route Numbe	r, City or Town, Sta	te, Zip Code) 21146
ore, ME ss Land 2 sl of Health ar If item 27 her traums	Leanne Kolma 20a. Method of Disposition 1 Burial 2 X Crem	ation 3 Removal from State.	20b. Place of Disposition (Nam	e of cemetery,	Date 2	Baltimore	or Town, State
Baltimore, permit. Pages 1 a Department of Ite Important: If ite injury or other tr	4 Donation 5 Other	er Specify: Deven II. William		ions Society ederick Road		and, Inc.	21228
yerician and burial - transit and ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying C (Disease or injury that initial events resulting in death). I	Due to (or as a consequence ted ast d. Due to (or as a consequence ted c. Due to (or as a consequence ted c. Due to (or as a consequence ted c. Due to (or as a consequence ted ted ted ted ted ted ted ted ted te	lence of):				
e be execut sysician and burial - tra	XUNPENDED	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				23d. Date of deliv	renv
ath certificat attending ph or use as the	IF FEMALE: 23b. Was decedent pregnar past 12 months? 1 Yes 2 No 9	t in the 23c. If yes, outcome 1 Live birth 4 Pregnant at tin g Unknown	2 Fetal death	3 Ectopic pregr	nancy	Month	Day Year
ires that the decires that the decire signed by the all be detached for the by Physical by	Part II. Other significant c	onditions contributing to death b	out not resulting in the underlying	cause given in Part I.			to the cause of death?
ing Physician: The law requires that the After this certificate has been signed by finneral director, page 2 should be detact on: To Be Completed by P	<u>Cocaine u</u>	se			1 Yes 24a. Was ar autopsy perform	24b. Were	autopsy findings availat to completion of cause of
Vital Records nysician: The law requititis certificate has been i director, page 2 should. To Be Complete					1 ✓ Yes 2		
tal I ician: certifi rector, Be (25. Was case referred to m examiner?	Hospital: 1 Inpatient		26.Place of Death (Chec		esidence 6 🗸 Of	ther: Scene
n of Vi ing Phys After this funeral di	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Yea		28c. Injury at Work?		w injury occurred	
ion (tending eath.	1 X Natural 5	Pending		1 Yes 2 No	Section 1		
Division of Vital Records, spital or Attending Physician: The law requirement Director: After this certificate has been sir filled in by the funeral director, page 2 should be Certification: To Be Completed	3 Suicide 6 Homicide	Could not be determined 28e. Place of Injur	ry - At home, farm, street, factory	/, office building, etc.	28f. Location (St or Town, Sta		Rural Route Number, C
Division To the Hospital or Attent within 24 bours after death To the Fineral Director: completely filled in by the Medical Certification	29a, Certifier	ing Physician: To the best of my kal Examiner: On the basis of examinand manner stated.	knowledge, death occurred at the nation and/or investigation, in m	e time, date and place, and opinion, death occurred	nd due to the cause d at the time, date a	nd place, and due to	o the cause(s)
A S S S S S S S S S S S S S S S S S S S	29b. Signature and title of	sertifier	29	c. License number		29d. Date signed (
	D-M	JI/C IMM		O.C.M.E.		January 2, 20	
	30 Name and address of t	person who completed cause of dea	atn (Item 23a)				
OK pend	Donna M. Vincen		al Examiner 111 Penn	Street, Baltimore,	MD 21201		

09-00029 Mi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

2009 00062

chael Kolettis			ent of Health and Mental Hy ate of Death	Reg. No.	
Physician	n/ 1	egistrar . Decedent's Name (First, Middle,Last)		2. Date of Death Month Day January 1, 2009	3. Time of Death Year 1859 hrs
edical Examin		Michael Kolettis ia. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death.	4c. Cou	inty of Death
,		Anne Arundel Medical Center Social Security Number 6, Sex 7, Age (In yrs. last birth	Annapolis If Under 1 Year If Under 24Hrs.		Arundel YYY) 9. Birthplace (State or
Funeral Director		216-94-1037 X M 2 F 41	Yrs. Months Days Hours Min.		Foreign Country) NJ
aug	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town			10d. Inside City Limits
daryland 28a-f show	اق	MD Anne Arundel Annap		10a. Citizen o	1 Yes 2 X No of What Country?
th the Maryland 23a or 28a-f sho	Director	3016 Arundel on the Bay Road	10f. Zip Code 21403		USA
73 4 0 9	ᇹ	11. Marital Status 1 X Never Married 2 Married Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- 14.	Race - American Indian, Black, White, etc.
her dea		Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:		city: White
nours af	1 g	10: 500000:10 20000:01 (05000)	Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret	work done 16b. Kind ired)	of Business/Industry
5-0036 led within 72 hours af Hygiene. other than "natural the Medical Examin	Completed	College (1-4 or 5+) O College (1-4 or 5+)	velopmentally Disabl		N/A
21215-0036 Juld be filed within 72 Mental Hygiene. marked other than "		17. Father's Name (First, Middle, Last)	18. Mother's Name Georg	e (First, Middle, Maiden Sur ia Liaromma	name)
2121 Id be 3 Mental marke event	o Be	19a Informant's Name/Relationship (Type, Print)	b. Mailing Address (Street and Number or	Rural Route Number, City o	r Town, State, Zip Code)
e, MD 2 1 and 2 shou Health and 1 item 27 is 1 r tranmatic	-	Nicholas Kolettis - father 5	675B Harpers Farm Ro	oad, Columbia	ation - City or Town, State
nore, MD 2 ages I and 2 shou nt of Health and N t: If item 27 is r		Zod. Modied of Bioperitori	of Disposition (Name of cemetery, tory or other place) Crematory, Inc. 01/0		cimore, MD
Baltimore, permit. Pages I an Department of He Important: If ite	N	4 Donation 5 Other Specify:			
Bal perm Depa Impo	II4	21. Signature of Funeral Service Licenses Williams	22 Cremation Society 299 Frederick Ro	ad, Baltimore	, MD 21228
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do n failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac	or respiratory arrest, shock,	or heart Approximate Interval Between Onset and Death
taminer		Immediate Cause (Final disease or condition resulting in death) a. Aspiration pneum Due to (or as a consequence of):	nonia		
		Sequentially list conditions, b	, lighted and		
	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated			
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Aecords, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	dical	Xunpended amended 23a,PII,2	27, permE, g887 1/23/		
760, ficate be g physicisthe buri	<u>a</u>	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnance 1 Live birth	y Fetal death 3 Ectopic pregi		Date of delivery onth Day Year
Box 6876 e death certificat the attending phi ed for use as the	iciar	past 12 months? 4 Pregnant at time of death	5 Other (Specify)		
ed the	Physician/M	Part II. Other significant conditions contributing to death but not resulting	ing in the underlying cause given in Part I.	23e. Did tobacco us	e contribute to the cause of death?
P.O.		Seizure disorder, profound ment		- 10 30 30 30	No 3 Probably 4 Unknown
ords, v requir s been s should	Completed by			24a. Was an autopsy performed?	24b. Were autopsy findings availab prior to completion of cause of death?
Recc The lavicate ha	I I		(2, 1) (0)	1 ✓ Yes 2 No	1 Yes 2 No
ital iiclan: s certif irector,	a	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 V ER/	26.Place of Death (Chec /Outpatient 3 DOA Other	sing Home 5 Residence	ce 6 Other:
i of Vital Records, P.C ing Physician: The law requires that After this certificate has been signed tuneral director, page 2 should be det	을 일	27. Manner of Death 28a. Date of Injury (Month Day Year)	b. Time of Injury 28c. Injury at Work?	28d. Describe how injury	accurred
sion ttendii death etor: A	atio	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	28f Location (Street and	d Number or Rural Route Number, C
Division of Vital Records, P.O. rate or Attending Physician: The law requires that the rate death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact.	Certification:	Suicide 6 Could not be determined (Specify)	, farm, street, factory, office building, etc.	or Town, State)	
Hospi 24 hou Funer stely fil	Medical Ce	29a Certifier	death occurred at the time, date and place, a prince investigation, in my opinion, death occurre	and due to the cause(s) and at the time, date and place	manner as stated. e, and due to the cause(s)
To the within To the comple	Med	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day Year)
		Afhn Brasself MD	O.C.M.E.	Janu	ary 2, 2009
6	1	30. Name and address of person who completed cause of death (Item 23a Melissa Brassell, MD Assistant Medical Examiner		ID 21201	
<u> </u>	State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	/		
Regi		JAN 0 6 2009 Bruss B. J	backer		
DHMH 17 Rev 1	/2001	OCME	DRIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 00063Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Evelyn Owens Kellum /Medical January 2009 8.00 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Health Care
5. Social Security Number 6. Sex Severna Park Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M **XX** F Months Days Hours Min January 28,192BMaryland Director 217-12-7816 85 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits show traumatic event, the Medical Examinar must be notified at 1 Tyes ZENo Marvland Anne Arundel Hanover Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 21076 United States 7708 Ridge Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: or Items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 ģ 1 ☐ Yes 2 No Specify: Specify: White 3 ₩idowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Department of Defense Clerk marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) outh and Mental F. Be Charles Huebel Ella Hromadnik ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health ar
Important: If Item 27 Is n 7810 Chestnut Grove Road, Severn , Md.21144 Thomas Owens/ Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Purial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/6/2009 Elkridge, Maryland Meadowridge Memorial 22. Name and Address of Facility Garl L. Kaufman Funeral Home 21. Signature of Funeral Service Licensee lacol M01275 7250 WashingtonBoulevard, Elkridge, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** VENTRACULAR FBRALLATION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner EXMICELLA Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner be executed CARDONYOPAT burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician at the burial Physician/Medical death certificate attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Ö the ☐Yes 2 No 9 Unknown þ σ. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş WE1 Tric / WavE1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No page certificate Lεf of Vital 2 🗆 No ZPLLATION 1 ☐ Yes 1 ☐ Yes Physician: Be Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this After th funeral 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c Injury at Work? or Attending Division 1 Natural 5 Pending investigation death, s after death,
I Director: A
id in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled in To the Hospital o within 24 hours aff To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40 nos Oter Kurses 2 ESE, HD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

			For State Registrar	State of Ma	aryland	•	rtment of F tificate of I		,	giene Reg. No	0000	ոոոհե	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) James V.		ister				2. Date of Dea Month January		y 2009	3. Time of Death 2:20 P.M	
-	Examin		4a. Facility Name (If not institution, give s Hill Haven Nursing				4b. City, Town, or Adelph	Location of Death		4c.	. County of Death		
	Funeral Director		5. Social Security Number 218–16–0108 6. Sex	7. Age	e (In yrs. las 84	t <i>birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 05-22-	1 922	9. Birthp Coun Mary	lace (State or Foreign try) and	
	Maryland I-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge	orges	-	Town or Loc					10	0d. Inside City Limits 1 ☐ Yes 2 🛂 No	
	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	Funeral Director	10e. Street and Number 4804 Fox Street 11. Marital Status	12. Was Decedent E	Ever in II S		10f. Zip Code 2074(Unit	izen of What Counced State 14. Race - Americ	s	
9600	nours after d ural", or iten	b	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo	1	□Yes 2XXIo	lispanic Origin? (Si an, Mexican, Puerto Specify:	Rican, etc.)		Black, White, e	te	
21215-	d within 72 t giene. er than "nati Ire Medica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5-		(Give life. L	lent's Usual Occup kind of work done o OO NOT use retired tomer Sei	during most of work d)	king		ind of Business/Ind	lustry	
yland	2 should be filed and Mental Hygi is marked other aumatic event, II	To Be C	17. Father's Name (First, Middle, Last) Harry Keister					18. Mother's Nam Virginia			Surname)		
e, Mar	l and 2 sh Health and sm 27 is m ther traum			oe. Print) ife	1.	4804	Fox_Stree	et, Colle	ge Park	,_Md			
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		20a. Method of Disposition 1 ABurial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		Mead	owrid		ial 1/9	y L. Ka	Elkr ufma	idge, Main Funera, Md.210	ryland l Home,Inc.	
68760, 7	Physician // Medical Examiner substitutions and physician and physician and the purial-transit substitution is the purial-transit substitution of the purial substitution is substitution and substitution in the purial substitution in the purial substitution in the purial substitution is substitution in the purial substitution in the purial substitution is substitution in the purial substitution in the purial substitution is substitution in the purial substitution in the purial substitution is substitution in the purial substitution in the purial substitution is substitution in the purial substitution in the purial substitution is substitution in the purial substitution in the purial substitution is substitution in the purial substitution in the purial substitution is substitution in the purial substitution in the purial substitution is substitution in the purial substitution in the purial substitution is substitution in the purial substitution in the purial substitution is substitution in the purial substitution in the purial substitution is substitution in the purial substitution in the purial substitution is substitution in the purial substitution in the purial substitution is substitution in the purial substitution in the purial substitution in the purial substitution is substitution in the purial substitution in the purial substitution is substitution in the purial substitution in the purial substitution is substitution in the purial substitution in the purial substitution is substitution in the purial substitution in the purial substitution is substitution in the purial substitution in the purial substitution is substitution in the purial substitution in the purial substitution in the purial substitution is substitution in the purial substitu	edical Examiner	23a. Part 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Immediate Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Complica Due to (or as a	tions a consequer	from nice of):	·	_		rrest,		Approximate Interval Between Onset and Death	
P.O. Box 68	death certi e attending d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Ectopic pregnanc	у			23d. Date of delivery Month Day Year					
	w requires that the debeen signed by the should be detached	by	Pneumonia								co use contribute to the cause of death? 2 ☒ No 3 ☐ Probably 4 ☐ Unknown		
Division of Vital Records,	The lay ate has page 2	Be Completed	Myelodysplasia Chronic Kidney I 25. Was case referred to medical	Disease				26. Place of Dea	1 □Yes	sy rmed? 2X□No	prior to cor death?	osy findings available inpletion of cause of 2 No	
	nysici nis cer direc		examiner? 1 ☐ Yes 2 🛣No	ospital: 1 🔲 Inpatie	nt 2 🗆 EF	R/Outpatien	t 3 DOA Othe				6 ☐ Other (Specify	·)	
sion o	To the Hospital or Attending Physician: whith 24 hours after death. To the Funeral Director: After this certification in the Funeral director, to completely filled in by the funeral director, to	Certification: To	27. Manner of Death 1	28a. Date of Injur (Month, Day	(, Year)	3b. Time of Injury			28d. Describe h				
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	Sold with	2	29b. Signature and title of certifier	W.S.			29c. License D4335				te signed (Month, L	Jay, Year)	
	7		30. Name and address of person who co Dr. Ikechi Okwara,					Berwyn H	eights,N	1d.2	0740		
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Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Certi				Ctate of Maryland / Dono		•	9	
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8+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tania hobertson, mo	= .	ng P	on:			28d. Describe how	injury occurred	
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8+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tania hobertson, mo	2	or At fter d ir by	ı#	determined 286, Place of Injury - At nome, farm, stre	eet, factory, office	 Location (Stre City or Town, 	et and Number or Ru State)	ral Route Number,
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8+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tania hobertson, mo		Hos 24 ho Fun Fun	lica	loneck only 2 Wedical Examiner: On the basis of examination and/or inv	n occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cau red at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
8+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tania hobertson, mo	:	ithin o the	Mec	and manner states.	29c. License number	290	d. Date signed (Month	Day Year)
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01' 1 3001 S. Hande a Stack Baltoniae 1000 21775		01.		30. Name and address of person who completed course of death (Itam 20c) (Time I	Print) T	· - l-r ·	2001 d16	007
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		1 - State of Maryland State of Maryland Registrar	/ Department of Health and M Certificate of Death		^{ne} ∞.2009	00066				
Physicia		1. Decedent's Name (First, Middle, Last) Emily Irene Kasper		2. Date of Death January	°4,2009	3. Time of Death 9:30A. M				
/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	4c. County of Death					
		1200 Hillcreek Road	Pasadena Pasadena		Anne Arı					
Funeral Director		5. Social Security Number 215-01-3811 6. Sex 1 M 2 F 7. Age (In yrs. las	t birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth April 5, 19	719 Man	hplace (State or Foreign untry Land				
and w		Usual Residence of Decedent 10a. State 10b. County 10c. City,			10d. Inside City Limits					
Mary -f sh	tor	Md. Anne Arundel P.	asadena			1 □ Yes 2 No				
h the	irec	10e. Street and Number	10f. Zip Code	1	Citizen of What Co	untry?				
23a c	Funeral Director	1200 Hillcreek Road	21122		J.S.A.					
tems	une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White					
filed within 72 hours after death with the Maryland Hygiene. Hygiene within than "natural", or items 23a or 28a-f show ant, it is mystical Examination in viting the control of the contro	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 24 ☐ No If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Ye ar or Dates:	es, Give 1 ∐Yes 2 L4No <i>Specify:</i>			White				
2 hou		15. Decedent's Education	16a. Decedent's Usual Occupation (Give kind of work done during most of work)	16b.	Kind of Business/	Industry				
thin 7 be. nan "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) O L n College (1-4or 5+)	life. DO NOT use retired))wn Home					
led w Lygier her tt	ပိ	O L I 1 17. Father's Name (First, Middle, Last)	Home Maker	(First, Middle, Maid						
ld be f lental l ked or ic eve	To Be	John Panek	1	ine Krol						
shou and M s mar	٦	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Rura	al Route Number, City	y or Town, State, 2	Zip Code)				
and 2 lealth m 27 i			1200 Hillcreek Road							
permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, its invalical Examination in the confined at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ce of Disposition (Name of netery, crematory or other place) Stanislaus Cem 1-8-	2009 Bal	Location - City or Location - Ci	, Maryland				
permit. Departr Importa any Inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility a C Z	orowski	Funeral	L Home, PA				
		23a. Part 1. Enter the disease, or complications that caused the death.	1201 Dundalk Ave		Imore,	Approximate				
Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	EB, CYMPHUBLARIC	(5 11 K	EWIL	Interval Between Onset and Death				
/Medical Examiner			Due to (or as a consequence of):							
± q	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	nce of):							
ficate be executed physician and s the burial-transit	Examiner	Cause (Disease or ińjury that initiated events resulting in death) Last Due to (or as a conseque)	nce of):							
e be e	edical E	L a								
1 4 0	ledi									
The law requires that the death certificate has been signed by the attending I bage 2 should be detached for use as	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ▼ No 23c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea	eath 3 Ectopic pregnancy		23d. Date of del Month	ivery Day Year				
at the by the tacher	Phys	9 ☐ Unknown								
res that	by	Part II. Other significant conditions contributing to death but not resulting to Death but not resulti				the cause of death?				
requi	eted	11 18 714 18 11 01 6 11		24a. Was an						
e 2	Completed	HYPOTHURVINISM HYPERLIPIINEIM		autopsy performed:	prior to death?	stopsy findings available completion of cause of				
	25. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 1 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 3 Residence 6 Other (Specify)									
hysic his ce I direc										
Attending Physician: r death. ector: After this certifica by the funeral director, p	ion:	1X Natural 5 □ Pending (Month, Day, Year)	28b. Time of lnjury M 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how in	jury occurred					
Atten r deatl ctor:	fical	3 Suicide 6 Could not be 28e. Place of Injury - At hom		28f. Location (Street		ural Route Number,				
rs after al Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, St	ate)					
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowl and manner stated.	ledge, death occurred at the time, date and place, on and/or investigation, in my opinion, death occur	and due to the cause red at the time, date a	e(s) and manner a and place, and due	s stated. to the cause(s)				
To the within To the comp	29c. License number 29d. Date D 21703 Janu									
1,5		30. Name and address of person who completed cause of death (Item 2	23a) (Type, Print)			21122				
N	•	Dr. Michael F. Garahy, M.D.		u ka.Sul	Le I, Pa	isagena, Md				
Sta Registr		31. Date filed (Manth Day Yer) 2009 33. Registrar's Signatu	- sparker							
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Physician /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Modical Evaninar must be notified at apresent any injury or other traumatic event, the "Modical Evaninar must be notified at apresent."

Baltimore, Maryland 21215-0036

4/00

NORMA KOHNO

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, 💉

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		not institution, give		,				r Location	of Death				y of Death		
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218	8–22–46	666 ¹	ex □M2∏xF	7. Age (In yrs. 83	Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Di Nov 2	19:	25	Goul	place (State or ntry) DC	roreign
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location													10d. Inside City	v imits
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		ed 2 Married	1 ∐Yes If Yes, Giv	e A		1 □Yes	2 No	Specify	' :			Speci	^{∱y:} whit	· e	
31	Widowed		Year or Da	ites:				notion			16b I				
	(Spec	15. Decedent's Ed ify only highest gra	ucation ide completed)		16a. Dece	kind of v	vork done	ation during mos d)	st of worki	ing	100.1	KING OF E	Business/In	iuusii y	
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		me/Refationship (1	-				al Route Numb n MD 2			ı, State, Zij	p Code)	
Glenn Kohne (son) 19522 York Rd., Parkton, MD 21120 20a. Method of Disposition Date 20c. Location - City or Town, State															
1 Burial 2 TCremation 3 Removal from State cemetery, crematory or other place)															
4 Donation 5 Other (Specify) All County Cremation 1-6-09 Sykesville, MD															
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195, Sykesville, MD 21784															
23a.	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between												veen		
Imm	ediate Cause	Final	one cause on ea	: \make	1 6								1	Onset and D	
resu	ase or conditio Iting in death)	n 🕜	a. Due to (Due to (or as a consequence of):										vays	
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	1 ☐ Yes 2 ☐ 9 ☐ Unknown	XI)40	9 ☐ Unkno				(-,,-								
Part I	II. Other signif	icant conditions	contributing to de	ath but not res	ulting in the u	ınderlying	g cause giv	ven in Part	l.	23e. Did	tobaccc	use cor	ntribute to	the cause of de	eath?
		Don	entri	C	UA					1 🗆	Yes	No No	3 ☐ Pro	bably 4 □ U	Jnknown
		— CVI		7	,						W.S.		Mess	onny fin die ee	ningaj Norda El
										24a. Was auto perf		240	prior to co death?	opsy findings a ompletion of ca	ivaliable
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е	Was case referexaminer?	_	Hospital:				O#	ner:	_	h (Check only					
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	lanner of Teat Natural	5 Pending		h, Day, Year)	28b. Time of Injury		28c. Inju Wor		711.	28d. Describe	now inj	ury occu	irred		
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	Homicide	determined	Zoe. Flace	of Injury - At h ng, etc. <i>(Speci</i>	ome, farm, st fy)	reet, fact	ory, office			28f. Location City or To	(Street a wn, Sta	and Nun te)	nber or Rui	ral Route Numi	ber,
			4												
29a.	Certifier (Check only	M☐ Certifying Pl	miner: On the ba	asis of examin)
	one)		and manr												
27. M 1 27. M 1 2 3 4	Signature and	title of certifier	3			1.2	29c. Licens	se number			29d. D	ate sion	ned (Month.	Day, Year)	

State

Registrar

31. Date filed (Month, Day, Year) JAN 0 5 2009

29b. Signature and title of certifier

30. Name and address of person

landikan

Joff

Ro completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

D03110

Park-ille

29d. Date signed (Month, Day, Year)

21234

2009

State of Maryland / Department of Health and Mental Hygiene 2 00068 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) , 2009 Year **Physician** Jamuary 1, 9:40pm M Katherine С. Kurtz /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Farihaven Health Care Center 9. Birthplace (State or Foreign Country)
7 PA 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🙀 F 1927 179-26-5381 81 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Manyland ment of Health and Mental Hygiene. The state of Health and Sas or 28a-f show ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show uny or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21784 USA 7200 Third Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White 2 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katherine S. Smith Clyde E. Carpenter 2 19a. Informant's Name/Relationship (Type. Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9124 Flamepool Way Columbia, MD 21045 Mrs. Katherine K. Graziani 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot once. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) County Cremation 1/2/2009 Sykesville, MD Name and Address of Facility NIGHT FUNERAL HOME & CHAPEL PA DOX 195 Sykesville, MD 21784 21. Signature of Funeral Service Licensee HA 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, dementia Immediate Cause (Final 5 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown s been signated by Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has le 2 page this certificate 1☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred Certification: (Month, Day Year) Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident I Director: A 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1/2/9 D0020021 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 7200 Third Avenue, Sykesville, MD 21784 Dr. Ana Surante, . Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 0 5 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** MARGARET BOYDEN 1:23 P^M January 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Greater Baltimore Medical Center Towson Baltimore Hours Min. 8. Date of Birth (Month, Day, Year) NoV 4, 1917 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M **X X** F Washington DC 577-20-8685 91 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Wedical Evantment or other traumatic events. Director 1 □Yes**x¾**□No Maryland | Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 29 Ruxview Court #201 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2000No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 🛚 Xo White \$ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Lillington Parker John Hanson Boyden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DTR 4704 Tobias Avenue Sherman Oaks California 91403 Susan Cornell Krebs 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2XXCremation 3 Removal from State GreenMount Crematory | Jan 5, 2009 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fac Witchell-Wiedefeld Funeral Home Inc gnature of Funeral Sorting Licens 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Hemory hagic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe certificate 2 NO 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 > Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier D0061199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) or Suite 209, Touson MD 21204 North Cha 6565 ac 32 Registrar's Signature 31. Date filed (Month, Day, Year) ___ State Registrar

DHMH 17 Rev 1/2001

Box 68760.

P.O.

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-00070 State of Maryland / Department of Health and Mental Hygiene John Drew Lindsay, Sr. 2009 00071 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 0632 hrs Medical Examiner January 3, 2009 John Drew Lindsay, 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Montgomery Silver Spring 1131 University Blvd. West # 2006 8. Date of Birth (MM/DD/YYY) 9. Birthplace (State or If Linder 1 Year | If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Mir Director Country) NY 057-20-9869 JUL 25 1927 81 1**X** M 2 F Vrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 X No s 23a or 28a-f show e notified at once. Silver Spring MD Montgomery Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 20902 1131 University Blvd., West, #2006 USA 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 1.1. Marital Status marked other than "natural", or items event, the Medical Examiner must be White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 1 X Yes Yes 2 X No specify: If Yes, Give Year 1945-52 Specify: Black Divorced Widowed ş 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) more, MD 21215-0036
Pages I and 2 should be filed within 72 I ent of Health and Mental Hygiene. Field Office Manager Dredging 2 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lindsay Agnes Doig Passmore R. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20902 19a. Informant's Name/Relationship (Type, Print) If item 27 is Mildred G. Lindsay - wife 1131 University Blvd., West, Silver Spring, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Baltimore, crematory or other place) Burial 2 x Cremation 3 Removal from State 01/05/2009 Metro Crematory, Inc. Baltimore, MD nent ant: Other Specify Donation 5 21. Signature of Funeral Service Licensee 21. Signature of Funeral Service Licensee

Williams

22. Name and Address of Facility.

Cremation Society of Maryland, II

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 21228 Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death Multiple injuries Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last 23a,PII,27,28a-f, perME. G887 1/20/09 Physician/Medical X UNPENDED ned by the attending physician detached for use as the burial requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Month Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o s been signed t should be deta þ Dementia Yes 2 ✓ No 3 Probably 4 Unknown Records, P. Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? Yes 2 1 1 Yes 2 No 26. Place of Death (Check only one) Fo the Hospital or Attending Physician: 25. Was case referred to medica Division of Vital Be Other₄ examiner? Hospital: , Residence 6 V Other: Scene FR/Outpatient 3 DOA Nursing Home 5 Inpatient 2 this ٩ 1 Yes 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Certification: Natural Yes 2X No Director: Pending 1/3/09 FD 6:30am 2 Accident Investigation 28f. Location (Street and Number of Bural Route Number City or Town, State) II31 University Blv #2006 Silver Spring, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 X Could not be Suicide house determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the F one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 4, 2009 O.C.M.E.

DHMH 17 Rev 1/2001 OCME 2006

31. Date filed (Month, Day, Year, Registra

30. Name and address of person who completed cause of death (Item 23a)

Pamela E. Sputhall, MD

6

Assistant Medical Examiner

Registrar's Signature

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6:05 P M Joseph Victor Lance 2, 2009 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Elizabeth Nursing Home Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Year) 4/12/1930 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. Days Hours 1X M 2 □ F Director 213-23-3661 78 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, 11 Medical Event and 1. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Director 1 ☐ Yes 2 → No Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 Terrace Drive 21090 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify. White δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 Store Manager Retail Food 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Victor E. Lance Catherine E. Pagano ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole A. Schleicher / Dau. 12 Terrace Drive, Linthicum, Maryland 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Ceme. 1/6/2009 Baltimore, Maryland 4☐Donation 5 ☐Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** welmmin disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) the burial-tran resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) his certificate has been signed by the director, page 2 should be detached a 1 Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 1 ☐ Yes 2 ☐ No 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No s after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral L To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

Box 68760,

P.O.

Division of Vital Records.

29b. Signature and title of certifie

tomuiD 31. Date filed (Month, Day, Year)

30, Name and address of person who completed cause of death (Item 23a) (Type, Pont) lend Rd And 100 Common /

1 KALTUK

32. Registrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 2009 9:37 James Edward Long Sr. January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Hours Months Days 1**X** M 2 □ F Director 25, Maryland <u>213-30-1756</u> 1933 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-1 shov traumatic event, the Medical Examinational by mother 1 ☐ Yes 2X No **Funeral Directo** Maryland | Bel Air <u> Harford</u> 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 105 Lexington Road 21014 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 SYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify δ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Private School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Regina Sweeney မ John Thomas Long 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and :
Department of Health
Important: If Item 27
any Injury or other tr. of Health 105 Lexington Road, Bel Air, Maryland, 21014 Elizabeth Long / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buria 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from Hilltop Service Corp. 1/7/2009 Towson, Maryland 21. Signature of Funeral 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 23a. Parf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final month **Physician** longue Cancer disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown pernatremia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 sl 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

director, this After within 24 hours after death,

To the Funeral Director: A
completely filled in by the fu

Medical 124

State

Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day, Year)

D20907

28c. Injury at Work?

Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Charles Street, Beltimore, Md

Marie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6.701 31. Date filed (Month, Day, Year)

5 Pending investigation

6 Could not be

determined

27. Manner of Death

1 Natural

3 Suicide

29a. Certifier

2 Accident

4 Homicide

(Check only one)

32: Registrar's Signature

Division of Vital Records, P.O. Box 68760, 至

		amend #2	20ь Plea Per	SET Type or State o	Print in	Black Ind	<mark>delible Ink.</mark> artment of F	Ensure A	II Copies Mental Hv	Are Legi aiene	ble.	
	•	For State Registrar			,		rtificate of l			Reg. No. 2 (009	00074
Physicia /Medic		1. Decedent's Nam	ne (First, Middl GAR	e, Last)		LED	NUM	JL	2. Date of De Month	Day	Year 2069	3. Time of Death
Examin				n, give street and nu Hospital			Bal	r Location of Death timore		4c. County	of Death	
Funeral Director		5. Social Security N 213-36-2	2064	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Jan. 25	th, Year 1939	9. Birthpl Count Mar	ace (State or Foreign try) land
ryland		Usual Residence o 10a. State	10b. County		10c. C	City, Town or Lo	cation				10	od. Inside City Limits
the Ma 28a-f s	Funeral Director	MD 10e. Street and Nu		N/A			Baltim	ore		10g. Citizen of V	What Coun	1 Yes 2 □ No
ath with 23a or	ral D	1322 Mc	Henry	Street				1223		United		•
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinal must be notified a once.	ρ	11. Maritai Status 1 ☐ Never Mari 3 ☐ Widowed	_	ried Armed F	edent Ever in lorces? No ive Dates:	I .	Was Decedent of H If Yes, specify Cuba 1 □Yes 2 XNo	lispanic Origin? (Si an, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)		e - Americ ck, White, e /: Whit	tc.
in 72 ho "natu	Completed		cify only highe	nt's Education st grade completed)		16a. Dece (Give life.	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of world)	king	16b. Kind of Bi	usiness/Ind	ustry
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uld be fil Aental F rked otl	To Be	17. Father's Name Edgar M						18. Mother's Nam	e Jeffer		1e)	
alth and I		19a. informant's N Annette		hip (Type. Print) - Daught	er	19b. Mailii 132	ng Address (Street 22 McHenr	and Number or Ru y Street	ral Route Numb , Baltir	er, City or Town, nore, MD	State, Zip 2122	Code)
Pages 1 anent of He				3 ☐ Removal from	State 20b.	Place of Disponding Hard	sition (Name of place) Park	ne)	2009 2008	20c. Location -		
permit. Departn Importa any Inju		21. Signatura bi F	A /	1	100H	22	2. Name and Addre	ss of Facility Am	brose Fi	uneral H	lome,	Inc.
		20a. Part1 Enter shock, or he Immediate Cause	art failure. List	complications that only one cause on	each line.	ath. Do not en	ter the mode of dyir					Approximate Interval Between Onset and Death
Physician /Medical Examiner		disease or conditi- resulting in death)	ion	Due to	(or as a conse	equence of):	va					
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icate be executed physician and transit	al Examiner	that initiated event resulting in death)	IS		(or as a conse	equence of):						
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for the Hospital or Attending Physician: The law requires that the death certificate is within 24 hours after death, within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 Tes 2 9 Unknown	2 months? □No	1 Live	itcome of pregi birth 2☐Fe gnant at time of nown	tal death 3	☐ Ectopic pregnanc ☐ Other (specify) _	у			te of delive onth	ry Day Year
w requires that the de been signed by the should be detached	þ	Part II. Other sign	ificant conditi	ons contributing to c	A ·		4	en in Part I.				e cause of death?
law requals beer	Completed	Greeph	ologae	ty /	Forti 1	lind	Foile	re	24a. Was	psy	prior to cor	osy findings available inpletion of cause of
sician: The law certificate has rector, page 2 a	மெ	25. Was case refe	erred to medica	1				26. Place of Dea	1 □Yes	2 □ No	death? 1 🔲 Yes	2 1 No
hysici this cer al direct	To B	examiner? 1∐ Yes 2⊡			•	☐ ER/Outpatie		ner: 4 🗆 Nursing H		dence 6 □Oth	ner (Specif)	/)
inding Path.	ation:	27. Manner of Dea 1 ☐ Natural 2 ☐ Accident	5 Pendir	ng 28a. Date (Moi gation	e of injury nth, Day, Year)	28b. Time o Injury	Wor	ryat k? Yes 2∐No	28d. Describe	how injury occur	red	
al or Atte s after de l Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could detern	nined 28e. Plac	e of Injury - At ling, etc. (Spec	home, farm, str	eet, factory, office		28f. Location (City or To	Street and Numb wn, State)	er or Rura	l Route Number,
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)	1 ☐ Certifyi 2 ☐ Medical	ng Physician: To the Examiner: On the and ma	e best of my ki basis of exami nner stated.	nowledge, deat nation and/or ir	th occurred at the ti	me, date and place opinion, death occu	e, and due to the arred at the time,	cause(s) and m date and place,	anner as s	tated. the cause(s)
To the withing To the complex	M	29b. Signature and	d title of certifie	HYJIC	IAN		29c. Licens	1543		29d. Date signe		
3		30. Name and add	ress of person	who completed cau	340 M	em 23a) (Type,	Print) FIMURE	STIB	ALTIMO	ORE, M	p L	1223
Sta Registr		31. Date filed (Mo	nth, Day, Year,	09 1000	Registrar's Sign	nature			<u></u>	,		
		- Unit		-								

State of Maryland / Department of Health and Mental Hygiene 200Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Month **Physician** 1, Karen J. Lyvers January 8:39 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery 8. Date of Birth (Month, Day, Year) Nov. 16, 1952 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. 56 Pennsylvania Director 220-60-3703 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City. Town or Location show er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1XYes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20886 19801 Helmond Way United States 2 should be filed within 72 hours after death v n and Mental Hygiene. is marked other than "natural", or items 23: Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Para Educator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be Edna Jones John A. Jenkins ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 & Department of Health an Important: If Item 27 is any injury or other trau Preston A. Lyvers/Husband 19801 Helmond Way, Gaithersburg, Maryland 20886 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State January 5, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc. 21. Signature of Funeral Service Licenses M01173 300 W. Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) **Physician** Acute archionnimonary /Medical Due to (or as a consequence of Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami physician and is the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ed by the detached Ö 9 Unknown 9 Unknown ₫. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s has certificate 1 □ Yes 2 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 ₹No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death

Director: / 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral D Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated Med Dorech 29b. Signature and title of certifier heat of Em 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MA 18101 Régistrar's Signature 31. Date filed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2009Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 9:53 A.M harles Lewis 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death -Alvert -rederick Calvert Memorial Hospital TINCE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 3 M 2 ☐ F 215-22-2360 80 July 6, 1928 Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits St. Mary's Charlotte Hall 1 ☐Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 29449 Charlotte Hall Road 20622 U.S.A 12. Was Decedent Ever in U.S. Armed Forces?

1. ★ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) American Can Comp. Mechanic 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian Charles Cochran Francis Lewis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2317 Ruth Avenue Edgemere, Maryland 21209 Carol J. Miller -daughter 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 1-7-2009 Baltimore, Maryland 4 □ Donation 5 NOther (Specify) Entomb 22. Name and Address of Facility Joseph N. Zannino Jr. F.H. 21. Signature Frequal Service Licenses 263 S. Conkling St. Baltimore, MD. 23a. Part 1. Enter the disease shock, or heart failure e, or complicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List inly on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroscleronic Cardinvascular disease or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown eumonic 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Congestive 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner or Attending Physician; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

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Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

items 23a

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item 27 i

Department of H Important: If Ite any Injury or ot once.

Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.

Saltimore, Maryland 21215-0036

MD

Director

by Funeral

Completed

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Examine Medical Certification: Director: To the Funeral I

by Physician/Medical Completed Be P

IF FEMALE:

27. Manner of Death 2 Accident 3□ Suicide 4 Homicide

29a. Certifier (Check only one) 6 ☐ Could not be

determined

JAN 06

32. Registrar's Sign

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

 Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D 50653 29d. Date signed (Month, Day, Year) 1-5-2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gyan - C. Surana 1200A

State Registrar

To the Hospital

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VH

			For State Registrar	State of Marylan		artment of			iene •9. No 2 0 0 9	00077
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Marth	a dip	ka	٦		2. Date of Dea Menth Jan		3. Time of Death
	Examin	er	4a. Facility Name (If not institution, give s Good Samaritan N 5. Social Security Number 6. Sex	Nursing Home			or Location of Detainore	rs. 8. Date of Birth	4c. County of Dea	
	Funeral Director		218-01-8154 Usual Residence of Decedent]M 2⊠F 94	Yrs.	Months Day	rs Hours Mi	n. (Month, Day 2 - 7 - 19	, Year) C	ryland
	he Marylar 28a-f ehow	ector	MD 10b. County N/A		y, Town or Lo Balti	more			0g. Citizen of What C	10d. Inside City Limits 11☑Yes 2☐No
	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heath and Mental Hygiene. Depertment of Heath and Mental Hygiene Important: If Item 27 is marked other then "naturel", or Items 23s or 28s-f show say injury or other traumatic event, the Medical Exam the must be notified at ODGs.	by Funeral Director	1024 South Decke	er Ave. Apt 12. Was Decedent Ever in U. Armed Forces? 1 Yes 2X No		10f. Zip Code 2122 Was Decedent of Yes, specify C	4	(Specify Yes or No- erto Rican, etc.)	USA 14. Race - Am Black, Whi	erican Indian,
Maryland 21215-0036	nn 72 hours a n "naturel", or Yedical Exem	Completed by	3 ☑ Widowed 4 □ Divorced 15. Decedent's Edur (Specify only highest grade Elementary/Secondary (0-12)	If Yes, Give Year or Dates: cation e completed)	16a. Dece	1 ☐ Yes 2 ☒ N dent's Usual Occ kind of work doi DO NOT use ret		vorking	Specify: WI	nite Andustry
ind 212	be filed with high high high high high high high h	Be	17. Father's Name (First, Middle, Last)	College (1-4or 5+) N/A	Cle	rk		ame (First, Middle, an Smial		су
Maryla	nd 2 should lith and Mer 27 is marke r traumatic	To	Alexander Majews 19a Informant's Name/Relationship (Ty, Jason Lipka - Gi	pe, Print)		-	et and Number or	Rural Route Numbe	r, City or Town, State,	Zip Code) NY 12603
Baltimore,	it. Peges 1 ar rtment of Hea rtant: If Item njury or other		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Donate	temoval from State Hol	Place of Disponentery, crea	osition (Name of matory or other p Sary Ce	em. 1-1	Date 0 - 2009	20c. Location - City of Dundalk,	Town, State
Ba	Depermine Deperm		23a. Part1. Enter the disease, or compli		12	201 Dur	ndalk Av	renue Ba	ltimore,	al Home, PA MD 21222
>	Physician /Medical Examiner		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq	uence of):	iso co	ndial	Infa	relion	Interval Between Onset and Death
8760,	icate be executed physicien and sthe burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq Due to (or as a conseq	uence of):					
P.O. Box 6	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	□Ectopic pregna □ Other (specify,			23d. Date of de Month	olivery Day Year
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on of Vital	Attending Physician: Trideeth. ector: After this certificet by the funeral director, pa	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpaties 28b. Time o Injury	of 28c. In	0		ne) ence 6 □Other (<i>Sp</i> ow injury occurred	əcify)
Division	5 g g c	Certification	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	(y)			City or Tow		
	the Hospital Inin 24 hours e the Funaral I mpletely filled	Medicai	29a. Certifier (Check only one) 20 Medical Exami	sician: To the best of my knot iner: On the basis of examina and manner stated.	owledge, deat ation and/or in	ivestigation, in m	e time, date and pla ny opinion, death of ense number	ccurred at the time,	cause(s) and manner a date and place, and du	e to the cause(s)
	5 William		30. Name and address of person who of	ompleted cause of heath /lter	TI 23ah(Type	Print) 2	30661		January	5/2009
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	Regist	rar	JANU 6 2009	Henry 10.	17					

			1 - State of Ma	aryland / Depa <i>Cel</i>	artment of Healt r <i>tificate of Dea</i>	th and Me ath	ntal Hygie _{Reg.}		9 00078
	Physici	an	Decedent's Name (First, Middle, Last)	-		2.	Date of Death Month	Day Year	3. Time of Death
	/Medic		JUNE C. LACKWOOD				ANUARY	1, 2009	
	Examir	er	4a. Facility Name (If not institution, give street and number) UNION HOSPITAL		4b. City, Town, or Locat	tion of Death		4c. County of Dea	ath
Ė	Funeral			e (In yrs. last birthday)	ELKTON If Under 1 Year If Un	nder 24 Hrs. 8	Date of Birth (Month, Day, Ye	CECIL 9. Bi	rthplace (State or Foreign
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	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
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	the P	Director	MD CECIL 10e. Street and Number	ELKTON	10f. Zip Code		10g.	Citizen of What C	
	h with	al D	105 WINDSOR DRIVE		21921			USA	
	ems (Funeral	11. Marital Status 12. Was Decedent Armed Forces?	ever in U.S. 13.	Was Decedent of Hispanio f Yes, specify Cuban, Mex	c Origin? (Specif	y Yes or No-	14. Race - Am Black, Whi	erican Indian,
36	or it	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ X	lo		ecify:	, 0.0.,	Specify: WH	
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ind	be file	Be	17. Father's Name (First, Middle, Last)			,	irst, Middle, Maid	den Surname)	
Σ	2 should be filed withir n and Mental Hygiene. Is marked other than raumatic event, Items	မှ	JOSEPH V. WEBER 19a. Informant's Name/Relationship (Type. Print)	405 Mailin		LSIE R.			
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Baltimore,	permit, Pages 1 and 2 should Department of Health and Mer Important: If item 27 Is marke any injury or other traumatic once.		20a. Method of Disposition		sition (Name of natory or other place)	Date		Location - City or	
<u>m</u>	Page nent c ant: If ury or		1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	FHMP	latory or other place)	1/8/0)9 E	XETOR, PA	Δ
alti	permit. Departr Importa any inju		21. Signatur of Funeral Service Licensee		. Name and Address of Fa	acility MILI		EL FUNER	AL HOME, INC
	205 20		TROX		415 BELAIR I			E, MD 212	206
			23a. Rant I. Enter the disease or complications that caused shock, or heart failure. st only one cause on each lin	the death. Do not ent e.	er the mode of dying, such				Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Fina disease or condition resulting in death)	te TWY	ocardio	7 7-1	itarc	tion	10 mins
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ŝ,	res th	٥	Part II. Other significant conditions contributing to death but	t not resulting in the un	derlying cause given in Pa	'art I.			o the cause of death?
Ö	w requir s been s should t	eted	Ity pertension				1 ∐ Yes	2 € No 3 □ P	robably 4 🗌 Unknown
Rec	has l	Completed					24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
tal	hysiclan: The la his certificate ha I director, page 2		25. Was case referred to medical		00 B	15 11 (6	1 ☐ Yes 2 ☐	No 1 □Yes	2 2 No
>	ysicia is cert direct	To Be	examiner?	nt 2 ☐ ER/Outpatien	Othori	Nursing Home		e 6 ☐ Other (Spe	anif d
5	ding Phy. h. After thi funeral o		27. Manner of Death 28a. Date of Injur	y 28b. Time of	28c. Injury at Work?		. Describe how is		icity)
Sio	ttendir Jeath. tor: Al	catic	2 Accident investigation	, , , , , , , , , , , , , , , , , , , ,	M 1 □Yes 2	2 □ No			
Division of Vital Records,	or Attenc after death Director: In by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inju building, etc	ry - At home, farm, stre . (Specify)	eet, factory, office	28f.	Location (Street City or Town, St	t and Number or R tate)	ural Route Number,
	Hospital 24 hours a Funeral (29a. Certifier 1 Certifying Physician: To the best of	of my knowledge, death	occurred at the time, dat	te and place, and	due to the caus	e(s) and manner a	e etated
	To the Hospital or Attending Physician: within 42 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director, p.	Medical	(Check only one) 2 Medical Examiner: On the basis of and manner sta	examination and/or inv	estigation, in my opinion,	, death occurred	at the time, date	and place, and due	e to the cause(s)
	To the To the comple	Me	29b. Signature and title of certifier	N	29c. License numb	per	29d.	Date signed (Moni	th, Day, Year)
	. ^		fore Il Vie IV	Ρ.	DHH	716	Na	war	1,2009
	17		30. Name and address of person who completed cause of de	eath (Item 23a) (Type, F	Print)	_1			
	Sta	20	31. Date filed (Month, Day, Year) 32. Registra	r's Signature	ST, EIK	< ton	, WD	. 219	21
	Registra		IAN 0 5 2009 /2 tuns	A. Sa	west .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12:03 AM 2009 Wilbur Leroy Lenhoff January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Health Center Bel Air If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 XM 2□ F 86 215-05-6284 October 26,1922 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County death with the Marylan If Item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, Ite Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Harford Baldwin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3207 Wellington Way 21013 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1X Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No Specify: white 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) federal government management analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Elizabeth Polk Wilbur Francis Lenhoff 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Celeste Hughes/personal rep. 3204 Wellington Way Baldwin, MD 21013 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages permit. Pages Department of Important; If II any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem Gard Jan. 5,2009 | Timonium, Maryland 21. Signature of Funeral Service Licenses John O. Mitchell IV, Funeral Services of Dulaney Valley 200 E. Padonia Rd. Timonium, MD 21093 P.A. 200 E. Padonia Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ntracerebra **Physician** hour /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsecuence of Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 □Yes 2 XNo Hospital or Attending Physician; filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 No 109 730 Trom after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Boute Number City or Town, State) 4 Homicide Residence
3201 Wellington Way Bullium

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causals) and manner as stated.

1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causals) e Funeral 29a. Certifier To the Hosp within 24 ho To the Fune completely f and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

102/2009

1585

LEroy M80034

Kevin

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

LYNLH

D35012

Chesapeake

12009

Bel Air, Md. 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00080 Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 3:45 PM Barbara. Ann Moore /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bal 力 9. Birthplace (State or Foreign Country) 05-6 dal uare 1105 DIta 1111 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Funeral Months Days Hours 1 □ M 2 😿 F 2-13-1949 VΑ 59 Director 219-50-2421 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Modical Exprine must be untified at once. 1√2Yes 2□No Director Baltimore MD N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21218 3521 Greenmount Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S 11 Marital Status Armed Forces? 1 ☐ Never Married 2 ☐ Married Black 1 ☐ Yes X No Specify If Yes, Give þ Year or Dates: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cleaning Services College <u>HOUSEKEEPING</u> 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosalee A. Carter 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Flagto, MD 21218 Greenmount 3521 Maurice Lucas- Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 1-12-2009 Owings Mills, MD Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Fune A Service Licensee Wrank- Mchin 1101 E. North Avenue Balto, MD 21202 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Konchin Due to (or as a consequence of) Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and burial-trar Due to (or as a consequence attending physician for use as the buria Physician/Medical 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Year Month Day 5 Other (specify) cate has been signed by the page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed

certificate

After 1

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

this certificaral director, p

Be Completed

Certification: To

Medical

Division of Vital Records, P.O. Box 68760,

show!

Maryland 21215-0036

altimore,

Mell. tus

24a. Was an autopsy 1 XYes

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death

12 Natural

2 ☐ Accident

3 🗌 Suicide

4 ☐ Homicide

5 Pending investigation

6 ☐ Could not be

determined

28a Date of Injury (Month, Day, Year)

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

Other: 4 \(\text{Nursing Home} \) 1 \(\text{Pecify} \) Residence \(6 \) Other (Specify) 28c. Injury at Work?

1 □Yes 2 □No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier

Kes 0000

-2000

Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MT grueire Drive Dr. Godit Negus 32. Registrar

State Registrar

		Please	Type or Prin State of Ma								•	e.	
		for State Registrar	Otato of Ma	ii y iai i a	-	tificate				Reg. N	000	10	กกกล
		1. Decedent's Name (First, Middle, La	ast)						2. Date of D	eath			3. Time of Death
Physicia /Medic		Carol Ann McDonal	ld						Januar	cy Q	1, 200	ar 9	3:10 A. M
Examin		4a. Facility Name (If not institution, gi Gilcnrist Hospice				4b. City, T		Location of Death			c. County of D altimo		County
Funeral Director		5. Social Security Number 6. 016-32-1182	Sex 7. Age 1 □ M 2 🖾 F	(In yrs. las		If Under	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D Feb. 24	irth 19, 19	42 L	Birthpl Count awr	ace (State or Foreign try) ETICE, Mass.
pu v		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	nation						10	Od. Inside City Limits
/aryla	5		d County		l Air								1 ☐ Yes 2 ☒ No
r 28a-	irec	10e. Street and Number				10f. Zip	Code			10g. C	itizen of Wha	t Count	try?
h with	aD	1705 Gatehouse Co	ourt				2	21014		U:	nited	Stat	tes
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Hygiene.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates;	ver in U.S.		Vas Decede fYes, speci ☐Yes 2		ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or N Rican, etc.)	0-	14. Race - A Black, V Specify:	Vhite, e	
"natura	Completed	15. Decedent's E (Specify only highest gi	Education		16a. Deced	lent's Usual	l Occup k done d	ation during most of world	king	16b.	Kind of Busin	ess/Ind	ustry
withir liene.	d wo	Elementary/Secondary (0-12)	College (1-4ar 5+	+)				" ool Teach			Edu	cat:	ion
e filed al Hyg other	Be C	17. Father's Name (First, Middle, Las	t)					18. Mother's Nam	e (First, Middle	e, Maide	n Surname)		
und be Menta arked	10 E	Lionel J. Begin		.,				Gertrude	Boucha	ard			
ind 2 sho alth and 27 is me		19a. Informant's Name/Relationship Mr. Michael R. Mc		n)				and Number or Ru K Court			or Town, Sta • Mary		
ages 1 gent of He ht: If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		20b. Pla cen Evan	ce of Dispo netery, cren S Fun	sition (Nam natory or oth eral (e of her plac Char		Date . 07,		Location - City Forest		_{wn, State} ll,Maryland
permit. F Departm Importar any injur		21. Signature of Funeral Service Lice	A	n SC			_			1			n Ctr.,P.A 21093
√ Physician		23a. Part . Ent . the disease or cor sho k or sea t fai ure. List only Immediate Cause (Final	100	the death. e.	Do not ente	er the mode	of dyir	ng, such as cardiac	or respiratory	arrest,	-1		Approximate Interval Between Onset and Death
/Medical Examiner	Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	a conseque	nce of):								10474
eath certificate be executed attending physician and for use as the burial-transit	Physician/Medical Exa	IF FEMALE:	Due to (or as a d							-1	004 Date		
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the beautificate.	hysician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗀 Fetal d	leath 3	Ectopic pr Other (spe		у			23d. Date o Month		Day Year
quires that en signed I uld be det	ρ	Part II. Other significant conditions	contributing to death bu	it not resulti	ing in the ur	nderlying ca	use giv	en in Part I.			0		e cause of death? ably 4 \(\sum \) Unknown
The law requir te has been s age 2 should l	Completed								per	s an opsy formed? 2 \(\sqrt{N}	prio dea	r to con th?	osy findings available npletion of cause of
Physician: The la	Be C	25. Was case referred to medical examiner?						26. Place of Dea	th (Check only			100	2-481140
hysic this ce	P	1 Yes 2 1 1 10	Hospital: 1 Inpatie					4 Li Nursing n	ome 5 Res	sidence	6 Mother (Specify	, Hospice
ding P. h. After i		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	ry , Year) 2	8b. Time of Injury	M 28	Bc. Injur Work	yat <br Yes 2 ⊟No	28d. Describe	how inj	ury occurred		
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not determined	be 290 Place of Inju	ry - At hom :. (Specify)	ne, farm, str			165 2 110	28f. Location City or To	(Street a own, Sta	and Number o	or Rural	Route Number,
Hospital 24 hours Funeral etely filled	Medical Co	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	Physician: To the best of aminer: On the basis of and manner sta	examination	ledge, deatl on and/or in	occurred a	at the til	me, date and place pinion, death occu	, and due to th rred at the time	e cause e, date a	(s) and mann nd place, and	er as st	ated, the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier						e number			ate signed (A		
25		30. Name and address of person who Jason Black	completed cause of de	eath (Item 2	23a) (Type,	Dul-A)		109					
Sta	ite	31. Date filed (Month, Day, Year)	SCOMPLETE Cause of de SCOMPLETE CONTROL 32. Jegistra	r's Signatu	10 J	30	11 TE	107 6	de Son	04 (1 112	0	(
Registr	ar	JANU62	009 Consum	e p	1. 1900	rece							·

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JANUARY 5 2009 JERRY /Medical 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 212-58-5684 10/02/1951 West Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show Examiner must be notified at Maryland Baltimore Middle River 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō Pages 1 and 2 should be filed within 72 hours after death with 2222 Coralthorn Road 21220 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XX No Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 200 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2/CXNo Completed by If Yes, Give Year or Dates: White 3 Widowed 4 Divorced of Health and Mental Hygiene. Item 27 Is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Virginia Mildred Miller John William Mull ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. Patricia Mull (Wife) 2222 Coralthorn Road, Baltimore, Maryland 21220 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ♣ Cremation 3 ☐ Removal from State Bayview Crematory 01/09/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility} Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 21. Signature of Funeral Service Licensee 23a. Part 1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. 5EPT C SHOCK Approximate Interval Between Onset and Death **Physician** DAY /Medical Due to (or as a consequence of) **Examiner** CHOLANGITI DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2170 1∐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation d in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000

Registrar DHMH 17 Rev 1/2001

State

M. D. 4940 EASTERN AVENUE BALTIMORE MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K.

31. Date filed (Month, Day, Year)

HLER

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Physician 2009 SANUARY 4 William Joseph Moore /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD BELAIR BELAIR HEALTH AND REHABILITATION (ENTER Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Days Hours 1 XM 2 ☐ F 9, 1939 Maryland Director 219-34-1552 Feb. Usual Residence of Decedent 10d. Inside City Limits Maryland 10c, City, Town or Location 10a. State 10b. County r 28a-f show notified at 1 □Yes 2 □XNo Director Maryland Bel Air Harford death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pe or ms 23a c USA 410 E. MacPhail Road 21014 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after intent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or itel any or other traumatic event, the Medical Examiner. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify. þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Butcher Shop 12 Owner/Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Catherine Currthers Claude Maxwell Moore ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4603 Kamet Court, Woodbridge, Virginia, 22193 <u>David Joseph Moore / Son</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp: 1-8-09 Towson, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. lege (uss 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 4□Pregnant at time of death ☐Yes 2☐No 9□Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Was a autopsy performe this certificate MITCLIAM 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, 1 Yes 2 No Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28b. Time of 28d. Describe how injury occurred Manner of Death 28a Date of Injury 28c. Injury at Work? I or Attending Fafter death. After (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 0063981

State Registrar

6 2009

Benjamin Y. Lee,

31. Date filed (Month, Day, -Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

M.D.

32. Registrar's Signature

669

Revolution

Havre de Graco, MD 21078

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760, <

		For 1 State	Pleas amend	e Type of Item 30 State o	Prin pe f Ma	t in B ryland						l Copies lental Hy				00001
		Registrar 1. Decedent's Name (First	st Middle	l ast)	<u> </u>		Ce	rtificate	e of L	Death)	2. Date of De		200	19	3. Time of Death
Physicia		KEVIN M. McQUI										Month JAN	01, Day	2009 Ye	ar	0825 aM
/Medic Examin		4a. Facility Name (If not in	nstitution,	give street and nu	mber)			4b. City,	Town, or	Location	of Death		4c.	County of D	eath	
		SHADY GROVE AD						ROC If Under	KVILL		r 24 Hrs.	0 D-44 D	-41-	MONTG		
Funeral Director		5. Social Security Number	r 6	i. Sex 1∏M 2□F	7. Age	91	ast birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D JUNE 3	ay, Year)	1	Counti	ace (State or Foreign ry) NY
		065.10.3552 Usual Residence of Dece	dent	^^		31						OONE C	,0, ,0			
show	ř	10a. State 10b.	County			10c. City	, Town or Lo	ocation							10	d. Inside City Limits
he Ma	ecto	MD MC	ONTGOME	ERY		C	CAITHERS	BURG 10f. Zip	Code				10g Citi	izen of What	Countr	1 □Yes 2 ¬No
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nd 2 salth an 27 is r trau		MICHELE McQUIL			DAUG	HTFR		Ü				/ILLAGE,		20886	-, -,	
ss 1 ar of Hea item		20a. Method of Disposition	on			20b. P	lace of Dispo	osition (Nan	ne of	i		Date		ocation - City	orTow	n, State
Page ment ant: If ury or		1 XXXSurial 2 □ Cre 4 □ Donation 5 □ 0			State		RAVIAN			· .	JAN 5	, 2009	STAT	TEN ISLA	ND,	NY
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaninar must be notified at once.		21. Signature of Funeral	Service Li	censee)		0	F	2. Name an INK FUN	ERAL	HOME,	P.A.					
402 % 0		K GRECORY FINK M01148 426 CRAIN HWY. S., GLEN BURNIE, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate the mode of dying, such as cardiac or respiratory arrest, Approximate the mode of dying, such as cardiac or respiratory arrest,												Approximate		
Physician		shock, or heart faild Immediate Cause (Final	dre. List of	ni) one cause on	each lin	e. NEUMON			,	3,		,				Interval Between Onset and Death O DAYS
/Medical		disease or condition resulting in death)	7	a Due to			uence of):								+-	O DATE
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r; The												1 □Yes	formed? 2XX No	deat	n? Yes 2	2 □ No
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ig Phy ter this neral c	J:U	27. Manner of Death	7 Dendies	28a. Date		ry	28b. Time of		8c. Injur	ry at	varanig ric	28d. Describe		· · · · ·	opecny,	/
eath. or: Af	catio	2 Accident	Pending investigation	ition				М	1 🗆	Yes 2	□No					
or Att	Certification: To	4 Homicide	determin	26e. Place	e of Inju ling, etc	iry - At ho c. <i>(Specif</i>	me, farm, st	reet, factory	, office				(Street ar) wn, State		r Rural	Route Number,
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	P - + 32.	-	Registrar 1. Decedent's Name (First, Midd	fle, Last)			lineale of	Dealli	2. Date of Dea		0)	3, Time,of Death
	Physici		Michael T. Mi						January	Day 204	Year	(040AM
	/Medio		4a. Facility Name (If not institution		umber)		4b. City, Town,	or Location of Deat		4c. Count		101
	4 10 8	T _a	Rosewood Cent	er			Owing:	s Mills		Ba1	timor	
	Funeral		5. Social Security Number	6. Sex 1 X M 2 ☐ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		(Month, Day	, Year)		place (State or Foreign
	Director		Usual Residence of Decedent		47				May 16,	1961	Mar	yland
	ryland	_	10a. State 10b. Count	у	10c. Ci	ity, Town or Lo	cation					10d. Inside City Limits
	ith the Marylar or 28a-f show	Director	Maryland Balti	more		Owing	gs Mills					1 ☐ Yes 2 📉 No
	ING Z1Z15-UU30 be filed within 72 hours after death with the Maryland tital hygiene. Ad other than "natural", or items 23e or 28e-f show avant. Itte Madical Examiner is ust be rectified at	Dire	10e. Street and Number	-			10f. Zip Code			10g. Citizen of		ntry?
	death wins 23s	Funeral	200 Rosewood 11. Marital Status	12. Was De	cedent Ever in L	J.S. 13.1		117 Hispanic Origin? (S ban, Mexican, Puerl	pecify Yes or No-	USA 14. Ra		can Indian,
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5	13-UU36 72 hours after dea "natural", or items	d by	3 Widowed 4 Divorce	d If Yes, G Year or			1 ☐ Yes 2 🗶 No			Specia	Whi	te
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0	ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental hygiene. item 27 is marked other than "natural", or items 23s or 28s-1 show then traumatic avant. The Modical Examitrist rust be restilled at		19a. Informant's Name/Relation			19b. Mailir	ng Address (Street	t and Number or Ru	ıral Route Numbe	r, City or Town	, State, Zij	o Code)
	ore, Missis and 2 of Health elitem 27 is rother tra		M. Corinne Ke 20a. Method of Disposition	ys/Mother			Carthage	e Road, S	pring Hi	11, FL 20c. Location		
Č			1 🗆 Burial 2 🔀 Cremation	3 Removal from	n State	cemetery, crer	natory`or other pla	1				
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20	Physician		Immediat · Cause (Fi al disease or condition		emphy	sema						Onset and Death
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76	Bath cert attendin for use	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of pregn birth 2 Feta gnant at time of c	al déath 3 🗆	Ectopic pregnanc	;у			ite of deliv onth	ery Day Year
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	is, F.C. box es that the death cer igned by the attendin be detached for use	by Pr	Part II. Other significant condit	N 4 - 1 1 1 1 1 -	death but not res	sulting in the u	nderlying cause gr	ven in Part I.	23e. Did to	bacco use con	tribute to t	he cause of death?
X	v requires been sig		CON	gestive	heart	t tal	lure		127	es 2 No	3 🗆 Prol	oably 4 Unknown
\$ 8	HECOLOS, he law requires the has been signed age 2 should be considered.	Completed							24a. Was a		Were auto	opsy findings available impletion of cause of
	The The sate h	Соп							perfor	med?	death? 1 🗌 Yes	•
41	VICAL MEC sician: The law certificate has b irector, page 2 s	Be	25. Was case referred to medic examiner?	Hospital:					ath (Check only or	ne)		
Į.	on or vital Kaling Physician: The Ind. After this certificate ha funeral director, page	. To	1 Yes 2 No 27. Manner of Death		Inpatient 2	ER/Outpatien 28b. Time of	t 3□ DOA O		lome 5 Residence 128d. Describe h			S) ICF/MR
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2	OVIVISION OF VITAL I or Attanding Physician: T after death. Diractor: After this certificat in by the funeral director, p	Certification:	3 ☐ Suicide 6 ☐ Could	mined 200. Flac	ce of Injury - At h	ome, farm, str	eet, factory, office		28f. Location (S. City or Town	treet and Numi	ber or Run	al Route Number,
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	thin 2 thin 2 of the	Med	one) 29b. Signature aportitle of certifi		nner stated.		29c. Licen	se numb <i>e</i> r	2	9d. Date signs	ed (Month.	Dav. Year)
	5 × × × 8		▶ (hu ki/	nman.MA								
	3		30. Name and address of person	who completed car	use of death (Iter	m 23a) (Type,	Print) A	5001	0	0.02		
				JAY LIPP	MAN, MC	20	o Rosew	000 Ln	OWING	S MIC	15/	1021117
	Sta		31. Date filed (Month, Day, Year	2 39.1	Registrar's Signa	ature						
	Registi	ar	1AN 0 6	2009	sua p	. , war	Ked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For	State of Ma	rylan					lental Hygi	ene		
			1 - State Registrar			Cer	tificate o	f Death		Reg	g. No.2	009	00086
	Physicia	an	Decedent's Name (First, Middle, Last							2. Date of Death JANU ARY	Day	Year	3. Time of Death
	/Medic		Bryan H. Milstred							JANU ALLY	JO	2009	6:40PM
	Examin	er	4a. Facility Name (If not institution, give	street and number)			4b. City, Town		of Death		4c. Cou	unty of Death	1
	E-manual.		Union Memorial 5. Social Security Number 6. Se	7. Age	(In vrs. li	ast birthday)	If Under 1 Yea	imore	24 Hrs.	8. Date of Birth		g. Birth	place (State or Foreign
	Funeral Director			M 2□F	78	Yrs.	Months Day	/s Hours	Min.	(Month, Day, 6/09/19	^{Year)} 930	Con	intry) MD
	D.		Usual Residence of Decedent										
	arylar show	_	10a. State 10b. County		10c. City	, Town or Loc	cation						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	8a-f	Director	MD Anne Ar	undel		Glen 1	Burnie			140			
	with the		10e. Street and Number 825 Bentwillow D	w 1 170			10f. Zip Code 2106			10		of What Cou	intry ?
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72		ပိ	17. Father's Name (First, Middle, Last)	2		Mecha	anıc	18 Mothe	ar's Name	(First, Middle, Ma		motive	<u> </u>
Maryland	0 0 0	Be (Bryan H. Milstre	d					ce Ly		arderr Car	name)	
<u>Z</u>	2 should be to and Mental is marked or raumatic eve	၀	19a. Informant's Name/Relationship (7)			19b. Mailin	a Address (Stre			al Route Number,	City or To	wn. State. Z	p Code)
Ma	ges 1 and 2 should nt of Health and Mer if item 27 is marke or other traumatic		Mrs. Elizabeth Mi		wife	1	•			Glen Bu			
ē,	item item othe		20a. Method of Disposition		20b. Pl		sition (Name of natory or other p					on - City or T	
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trac		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	I		remator		1/07	/2009	Glen	Burni	e, MD
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Вох	death certific e attending p d for use as	an/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth			Ectopic pregna	ancy			23d.	Date of delige	very Day Year
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σ.	that the led by th detache	Ph	Part II. Other significant conditions co	ntributing to death bu	it not resu	ıltina in the ur	nderlving cause	given in Part I		23e. Did toba	cco use o	contribute to	the cause of death?
Division of Vital Records,	The law requires that the de ate has been signed by the bage 2 should be detached	d by		· ·						1 ☐ Yes	2 🗆 N	lo 3□ Pro	bably 4 Unknown
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æ	0 - 0	m d								autopsy performe	ed?	prior to codeath?	ompletion of cause of
ta		Be C	25. Was case referred to medical					26. Place	of Death	1 Yes 2 (Check only one)	ZHVo	1 ☐ Yes	2 LI No
	Physician: this certificanal director, partition	70 B	examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 Inpatie	nt 2 🗆	ER/Outpatien	nt 3 DOA	Other:		me 5 ☐ Residen		Other (Spec	ify)
0	ng Ph fter th neral	L:UC	27. Manner of Death 1 Matural 5 □ Pending	28a. Date of Injur	ry /, Year)	28b. Time of Injury	28c. Ir	njury at Vork?		28d. Describe how			
<u>Si</u>	eath. or: A the fu	catic	2 ☐ Accident investigation				M 1	□Yes 2□	No				
Ë	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubuilding, etc	iry - At ho :. <i>(Specif</i> y	me, farm, stre /)	eet, factory, offic	e		28f. Location (Stre City or Town,		umber or Rui	ral Route Number,
Ω	pital ours a srai Derai Dilled		29a. Certifier 1	nigian: To the heat	of my know	ulodgo doath	a accurred at the	o timo data a	nd plane	and due to the sec		d manage on	atatad
	Hos 24 hc Fun etely	Medical	(Check only one)	ner: On the basis of and manner sta	examinal	tion and/or in	vestigation, in m	ny opinion, dea	ath occur	red at the time, dat	te and pla	ice, and due	to the cause(s)
	To the Hospital or Attending Physician: within 42 hours after death: To the Funeral Director: After this certific completely filled in by the funeral director.	Me	29b. Signature and title of certifier		•			ense number			d. Date si	gned (Month	, Day, Year)
			I solle, 1	1.0.			AT	-243	894	16 3	ANUF	ARY OF	,2009
	- 1-1		30. Name and address of person who co				Print)			1		-	
	5+1		ANDREEA OLAR				EMORI'	AL Hi	SPIT	TAL, B	ALTI	MORE	MD
	Sta Begistr		31. Date filed (Month, Day, Year)	32. Registra	ar's Signat	ture							

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F rtificate of		d Mental Hy	giene Reg. No.	2009	00087
			1. Decedent's Name (First, Middle, La.	st)				2. Date of De Month			3. Time of Death
	Physici /Medic		Anne V. Muelle	r				Januar			11:37 A ^M
- may	Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o		eath		County of Death	
قر سهر			Shady Grove Adve			Rockvi		(m) (m)		Montgom	
ı	Funeral Director		351-12-0681	ex 7. Age □ M 2 K F	(In yrs. last birthday, 83 Yrs.	If Under 1 Year Months Days	If Under 24 h	fin. 8. Date of Bin (Month, Did Jul. 26	th ay, Yea <i>r)</i> 5, 192	9. Birth Cou 111	place (State or Foreign ntry) inois
	yland how		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	e Ma	Director	Maryland Montgom	ery	Rockvill	Le					1 X Yes 2 □ No
	or 28	Dire	10e. Street and Number			10f. Zip Code	_			zen of What Cou	
	s 23a	ral	1012 Brice Road			2085		\(\(\text{O} \) = \(\text{V} \) = \(\text{O} \)		ed State	
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it is Wedfool Exa	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates:	ver in U.S.	Was Decedent of HIf Yes, specify Cuba 1 □ Yes 2 No	Specify:	r (Specify fes of No Jerto Rican, etc.)		14. Race - Ameri Black, White, Specify: Wh	
21215-0036	in 72 hc n "natur Nedical	Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+	(Give	edent's Usual Occup e kind of work done DO NOT use retire	during most of	working	16b. Kir	nd of Business/In	ndustry
212	d with giene er tha	E O	Elementary/Secondary (0-12)	1		ales			Fo	od Dist	ributor
pu	al Hy l othe	Bec	17. Father's Name (First, Middle, Last,					Name (First, Middle		Surname)	
<u>yla</u>	Ment Ment arked atic e	ျာ	Benjamin Verkle	r			I	aura Holu	ıb		
Maryland	and 2 should be filed within 72 eath and Mental Hygiene. n 27 is marked other than "nater traumatic event, the Medi		19a. Informant's Name/Relationship (ı	ing Address (Street					
6)	1 and 2 Health tem 27 is		Gail Gleeson/Dau	ghter		2 Brice R				cation - City or Te	0852
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 \(\overline{\text{Q}}\) Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Montgomery	osition (Name of matory or other place Crematoric	ım 2	nuary 6 2009	Beth	nesda, M	aryland
Ball	permit Depar Impor any In		21. Signature of Funeral Service Licer	hupling	M011/3	2. Name and Addre Robert A. P 300 W. Mon	tgomery A	Avenue, Roc	kville	ckville, Aarylan	Inc. d 20850
and the	Physician	li) 1	23a. Part1. Enter the disease, or com shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	plicate ns the caused to one cause on each line one cause on each line one and an each line on the caused to one caused to one one one one one one one one one on		iter the mode of dyli	ng, such as car	diac or respiratory a	arrest,		Approximate Interval Between Onset and Death
-/	/Medical Examiner		resulting in death)	Due to (or as a	consequence of);						
/	uted n	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	bDue to (or as a	consequence of):			· · · · · · · · · · · · · · · · · · ·			
<u></u>	exect n and ial-tra	Еха	that initiated events resulting in death) Last	Due to (or as a	consequence of):						
68760,	cate be ohysicia the buri	edical	(d							
O. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 \overline{\text{ZNO}} 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3	□ Ectopic pregnand □ Other <i>(specify)</i> _	у		2	23d. Date of deliv Month	very Day Year
Ф.	ned by	by Ph	Part II. Other significant conditions	ontributing to death but	t not resulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
rds	quire:	ed b	Atrial Fibrill	ation				_ 1 🗆	Yes 2	X No 3 □ Pro	bably 4 Unknown
of Vital Records,	The law re te has bee age 2 sho	Completed	Ischemic Cardi	omyopathy						24b. Were auto prior to co death? 1 \sum Yes	opsy findings available ompletion of cause of
ta	rtifica ttor, p	Be C	25. Was case referred to medical				26. Place of	1 □Yes Death (Check only		I LI 163	2 🗆 100
f V	nysic nis ce direc		examiner? 1	Hospital: 1 🔯 Inpatier	nt 2 ER/Outpatie	ent 3 DOA Oth	er: 4 🗆 Nursir	ng Horne 5 ☐ Res	idence 6	6 □Other (Speci	ify)
ion o	ath. r: After the funeral	Certification: To	27. Manner of Death 1 M Natural 5 □ Pending 2 □ Accident investigatio		y 28b. Time (Year) Injury	ToW 1	ry at k? Yes 2 □ No	28d. Describe	how injury	y occurred	
Division	al or Atte s after de il Directo	Sertific	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, farm, s (Specify)	treet, factory, office		28f. Location City or To	(Street and wn, State)	d Number or Rur)	al Route Number,
	n 24 hour ne Funera	Medical (nysician: To the best on Iner: On the basis of and manner state	examination and/or i						
	To the To the Comp	Me	29b. Signature and title of certifier			29c. Licens				te signed (Month,	
	. 0		1 Cole	22/		D	0064502		Ja	nuary 3,	, 2009
	\mathcal{W}		30. Name and address of person who								
	5		Brian Carpenter,		1 Medical	Center D	rive, R	lockville,	Mar	yland 2	20850
	Sta Regist		31. Date filed (Month, Day, Year) JAN 06		r's Signature	how Had					
	- regist	-11	JANO	LUUJ JURNUS	von p.	con con con					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month George Lawrence Morrow 009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Social Security Number 9. Birthplace (State or Foreign 212-32-6466 70 Months Days Hours J*a*m28°, 1938 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore 1 ☐ Yes 2 ☑ No Rosedale 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 1907 Summit Avenue 21237 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 14 Race - American Indian 1 □ Yes 2 □ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes Ž□No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Flooring Elementary/Secondary (0-12) College (1-4or 5+) Floor Mechanic Supervisor Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hubert L. Morrow Julia Bears 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Morrow (wife) 1907 Summit Avenue Rosedale, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith : 1-6-2008 Baltimore, Maryland 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee Dundalk Avenue Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ue to (or s a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last monia Due to (or as a consequence of) IF FEMALE yes, outcome of pregnancy □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 1 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Madical Event near rust be notified at once.

MOKTOW, CCORGE Itimore, Maryland 21235-0036

the Maryland

Examiner signed by the attending physician and a betached for use as the burial-transit Certification: To After this

Physician/Medical ⋧ Completed Be

The law requires that the death certificate be executed reral urector: After this certificate has been silled in by the funeral director, page 2 should To the Hospital or Attending within 24 hours after death. To the Funeral Director: After

Division of Vital Records, P.O. Box 68760,

5+1

State Registrar

ca

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

31. Date filed (Month, Day, Year) JANUU

6 Could not be determined

2 Accident

4 Homicide

29b. Signature and title of certifie

3 Suicide

29a. Certifier (Check only one)

Registrar's Signature

timore, Maryland 21215-0036

Balt	permit.	Depart	Import	any Inj
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Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
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	_	For State Registrar					ertificate of				Reg. No. 2	009	00089
Physicia /Medic		1. Decedent's Name Timothy	e (First, Middle, Allen M							2. Date of De Month	ath Day Z	Year	3. Time of Death
Examin		4a. Facility Name (If			iber)		4b. City, Town, o		of Death imore	,		ty of Death	
Funeral Director		5. Social Security No. 212-54-079	lumber 6		7. Age (In yrs. 60	last birthda Yrs.	y) If Under 1 Year Months Days	If Unde Hours	Min.	8. Date of Bir 03–14–15	th 148 ear)		place (State or Foreign Sylvania
		Usual Residence of 10a. State			10c. Ci	ty, Town or	Location						10d. Inside City Limits
he Mary 28a-f sh	Director	Maryland 10e. Street and Nun		I/A			Baltimore				10g. Citizen o	f What Cou	1 X Yes 2 No
23a or	ral Dir	5423 Hill		ie				21206			rog. Olizon o	U.S.A	
urs after dea al", or Items	by Funeral	11. Marital Status 1 Never Marri 3 Widowed	ied 2□ Marrie	12. Was Dece	ces? 2 [XNo e	.S. 13	3. Was Decedent of H If Yes, specify Cub 1 □ Yes 2 💆 No	lispanic C an, Mexic Specif		pecify Yes or No Rican, etc.)	Spec	ace - Ameri ack, White, aify:	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merial Hylpiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Marical Evan, from must be indifined at once.	Completed	(Spec		Education grade completed) College (1-	4or 5+)	(Gir	cedent's Usual Occup we kind of work done on DO NOT use retire ool Teacher	oation during mo d)	ost of work	sing	Baltimor Public S	e City	
be filed ntal Hyg id other event,	Be	17. Father's Name (ast)	·	<u> </u>				e (First, Middle,		ame)	
should and Mer s marke sumatic	ပ	John A M 19a. Informant's Na	ame/Relationship				iling Address (Street	and Num			er, City or Tow	n, State, Zi	p Code)
t and 2 Health tem 27 l		Mr. Butch Z		Brother	20b. I		pring Avenue position (Name of rematory or other pla			ville, MD	21093 20c. Location	n - City or T	own, State
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permit Depar Impor any Ir		21. Signature of Fu	uneral Service Li	Mire /	4.	L	22. Name and Addre eonard J. Ru		,		re, Mary		214
Physician /Medical Examiner	ner	Immediate Cause (disease or condition resulting in death) Sequentially list configure, leading to implementations.	(Final on	aDue to (/	uence of):	Hamps	ng, such a	es cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
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the death certi y the attending iched for use a	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		irth 2 Feta ant at time of	al death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _				1	Date of delive	very Day Year
quires that en signed t	ρ	Part II. Other signif	ficant condition	s contributing to de	ath but not res	sulting in the	underlying cause giv	ven in Par	t I.		obacco use co Yes 2 ☐ No		the cause of death? bably 4 Unknown
ding Physician: The law re h. After this certificate has ber funeral director, page 2 sho	Completed									1 □Yes	psy prmed? 2 No		opsy findings available ompletion of cause of
nystciar nis certif director	To Be	25. Was case referexaminer? 1 ☐ Yes 2 ☑		Hospital:	npatient 2] ER/Outpat	ient 3 DOA Oth	or:		th <i>(Check only o</i> ome 5 ☐ Resi	,	Other (Spec	ify)
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the temperal process.	Certification:	27. Manner of Deat 11 Natural 2 Accident 3 Suicide 4 Homicide	th 5 Pending investiga 6 Could no determin	ot be 28e. Place	h, Day, Year)	28b. Time Injurgiome, farm,	/ Wo	ryat rk?]Yes 2[□No	28d. Describe 28f. Location (City or To	Street and Nur		ral Route Number,
ospital or hours at uneral D		29a. Certifier (Check only					eath occurred at the t						
To the H within 24 To the F complete	Medical	one) 29b. Signature and		and manr			29c. Licen:				29d. Date sign		
		30. Name and addr	race of parcon "	2 Ph	il Bre	m 23a) (Tim	e Print)	101	-84		114	109	
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Sta Registr		31. Date filed (Mon	JAN 05	2009	giorar's Sign	A. A	barkel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 00090 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1,2009 Month **Physician** January 6:20P Thomas L. Moneypenny /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balto. Towson Stella Maris 8. Date of Birth (Month, Day, Year)
December 3,1913 West Virginia If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Min. **1** M 2 □ F Months Days Hours December Director 369-18-9088 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 ☐ No Director Balto. Nottingham Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21236 USA 9113 Gardenia Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 X Married White If Yes, Give Year or Dates: 1 ☐ Yes X☐ No Specify: <u>≥</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry 12 Car Repairman 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Ima M. Beall Thomas L. Moneypenny 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9113 Gardenia Rd. Nottingham, Md. 21236 Ethel M. Moneypenny Spouse Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State 1-5-2009 Bel Air Memorial Bel Air, Md. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek 9705 Belair Rd. Nottingham, Md.21236 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 2 No Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 9 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2X No 1 ☐ Yes 2 ☐ No 1 □ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 【 Other (Specify) 1 ☐ Yes 2 🛣 No 2 HOSPICE 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal one) X Nurse Practitioner stated. To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

21215-0036

2009

January

THOMAS MONEYPENNY

Registrar DHMH 17 Rev 1/2001 TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

2. Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP

JACKIE JONES,

JAN 0 5 2009

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #17 Per FH 6887 of Maryland/Department of Health and Mental Hygieneo O O O

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 13PM **Physician** Joseph Fredrick Munafo 2009 /Medical 4c. County of Death 4h City Jown, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bathmore 8. Date of Birth (Month, Day, Year) Aug 4,1949 Social Security Number (In yrs. last birthday) **Funeral** Months Days Hours 1**火**□ M 2□ F 59 Maryland 215-54-3727 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show Department of Health and Mental Hygiene important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Expression must be notified at any injury or other traumatic event, the Medical Expression must be notified at once. 1 ☐ Yes 2√ No Director MD Baltimore Nottingham 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21236 USA 7910 Marfield Place Apt B Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ∐Yes 2**XX**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married [MMA + 0, J0SeO] Baltimore, Maryland 21215-0036 1 ∐Yes 2 🛣 No Specify White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Emplyed Bar Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Munafo Edna M. Herrmann Salvatore Anthony 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lutherville, Maryland 21093 405 Chapelwood Lane Joann Koch / Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hillton Serv. Corp. 1/9/2009 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21204 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical undo (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the buriat-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed? After this certificate has funeral director, page 2 s 2 🗆 No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Medical Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daltimore md 21237 Eadd Kenneth State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 00092 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mary F. Nunn January 2009 12:04 a ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5320 Dorsey Hall Road, Apt. 122 Ellicott City Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. JAN 8 1931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 M 2 N F 218-28-8496 77 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Modical Exprised in the Landbed at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 TYes 25 No Director MD Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? 5320 Dorsey Hall Road, Apt. 21042 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. 3 ☐ Widowed 4 Noivorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anthony W. Haze1 Harmon Upton ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William R. Nunn -228 Palmetto Dunes Circle, Naples, FL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Metro Crematory, Inc.01/05/2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licenses Wil 22 Name and Address of Facility Cremation Society of Maryland, Inc. Williams 299 Frederick Road, Baltimore, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Concer melastatic mont /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Mesidence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 MAccident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide

P.O. Box 68760 Division of Vital Records, ours after death.

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filled in by the fu within 24 hours a

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 30. Name and address of person wholcompleted cause of death (Item 23a) (Type, Print) MILL 31. Date filed (Month, Day, Year) 32. State Registrar 06

8186 egistrar's Signature

MM

29c. License number

29d. Date signed (Month, Day, Year)

2009

			State of Maryland / Department of Health a State of Maryland / Department of Health a Certificate of Death			ene 3. No. 200	9 00093
h	Physicia		1. Decedent's Name (First, Middle, Last) Aleck Nagy		Date of Death Month	Day Ye	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Arden Courts of Towson Assisted Liv. Towson	of Death	aridar y	4c. County of D	
Ī	Funeral Director		5. Social Security Number 192–12–3630 6. Sex 1 Nage (In yrs. last birthday) 1 Norths Days Hours 192–12–3630 87 Yrs.	Min.	Date of Birth (Month, Day, 11y 05,	Year) 9.	Birthplace (State or Foreign Country) ista, Hungary
	laryland show	or	Usual Residence of Decedent 10a. State			· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits 1 □Yes 2 ☑No
	with the Na or 28a-1	Funeral Director	10e. Street and Number 10f. Zip Code 21204	1	109	g. Citizen of What United	
36	be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, I'm Marilea Evaruineust be notified at	by Funera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Or 12. Yes 2 No 13. Was Decedent of Hispanic Or 14. Yes, specify Cuban, Mexicar 15. Yes 2 No 16. Yes 2 No 17. T.	rigin? (Specify n, Puerto Rica	/ Yes or No- an, etc.)		merican Indian,
Maryland 21215-0036	hin 72 hours e. an "natural "	Completed b	3 ☐ Widowed 4 ☐ Divorced Year or Dates: VV • VV • 1 1 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during mos	st of working	16	6b. Kind of Busine	
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arylar	should and Mer s marke umatic	To E	John Nagy Sara 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number	Nagy Der or Rural R	oute Number, (City or Town, Sta	e, Zip Code)
Ë e,	Hea Hea ther	8	wir. Edward O. Uhrig (Guardian) 1024 Trinity Road 20a. Method of Disposition (Name of	Fe	lton, 1	PA. 173 Oc. Location - City	
	0 - - -		Was Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, ciematory or other place) Ulaney Valley Mem.	Jan. 06 2000	2/2	Timoniu	n.Marvland
Ba	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Peaceful Altern 2325 York Road	atives Ti	Funera monium,	al&Crema Marylan	tion Ctr.,P.A. d 21093
+ F	Physician /Medical		23a. Parta Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart if illue. List only one cause on each line. Immediate Cause (Firm disease or condition resulting in death) Due to (or as a consequence of):	s cardiac or re	espiratory arres	st,	Approximate Interval Between Onset and Death
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	lo the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	edical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date as 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, decand manner stated.				
	o the within To the compl	Med	29b. Signature and title of certifier 29c. License number	112	290	d. Date signed (M	onth, Day, Year)
•	10 81		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	+	RI	04/2	0f2 M 77 120
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 009 For State Registrar 00094 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 10:15A M Jacqueline January 2009 Neyhart 2, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F 212-26-9997 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23a or 28a-f show the Medical Examiner must be inclined at MD Anne Arundel 1 ☐ Yes 2 ☑ No Linthicum Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 E. Maple Road 21090 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 end 2 should be filed within 72 hours after nent of Health and Mental Hygiene. snt: if item 27 ie marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify. þ 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Protocol Officer Dept. of Defense or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Edward Green Marie Edith Bennett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Debora McGowan /Daughter 301 E. Maple Road Linthicum MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jan. 20, Burial 2 ☐ Cremation 3 ☐ Removal from State Department of importent: if eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem. Arlington, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Moi35-7 Services 1 2nd Avenue SW Glen Eurnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or lear failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician linkinown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): igned by the attending physicien be detached for use es the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate 1 Yes 2 No 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral (Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Dhawan D0062534 5 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) old Mill bottom Annapolis 31. Date liled (Month, Day, Year) -- -State 0 6 2009

DHMH 17 Rev 1/2001

Registrar

		,	State of Maryland / Dep	ertment of Health and Nertificate of Death		ene 3. N2 0 0 9	00095
			Registrar 1. Decedent's Name (First, Middle, Last)	er tillicate or Death	2. Date of Death	1. No. 0 0 3	3. Time of Death
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	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	(ear) 9. Bir	thplace (State or Foreign ountry)
	Director		217-11-1646 ¹ ₩ ² □ F 75 Yrs.		Feb. 17,	1933 Vie	tnam
and	W.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
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	Menta arked attc e	၉	Sach Van Nguyen	Long	Bui Thi		
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Dallillor Dermit. Pages	Department of Health and Mental Hygiene. Important: yor items 23a or 28a-f show any injury or other traumatic event, it e Medical Examination must be ruffled at once.			Crematorium 200		Bethesda,	
Dern De	Depar Impor any ir		21. Signature of Funeral Service Licensee William a. Sunshill M01173	2. Name and Address of Eacility Robert A. Pumphrey Fun 7557 Wisconsin Avenue	neral Home, Bethesda,	Bethesda-C Maryland 2	hevy Chase, Inc 10814
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between
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Physic C	this c	ျှ	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatie		me 5 Residenc	ce 6 ☐ Other (Spe	cify)
ding F	After funera	ion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day, Year) 28b. Time of Injury (Injury)	Work?	28d. Describe how	injury occurred	
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5 <u>5</u>	after I Dire d in b	Certification:	4 Homicide determined building, etc. (Specify)	,	City or Town,		, an instance,
ospita	hours unera		29a. Certifier (Check only 1	th occurred at the time, date and place,	and due to the cau	ise(s) and manner as	s stated.
To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death. To the Funeral Director; After this certificate has completely filled in by the funeral director, page 2	Medical	one) and manner stated.				
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)			Eanal Maria	D044957	om M D	12/200	
	10		30. Name and address of person who completed cause of teath (Item 23a) (Type, 7600 CAROLL Aug.) TAKOM	1 Blow Min	er, M.D.	0912	
	Sta	_	31. Date filed (Month, Day, Year) JAN 0 6 2009 22. Registrar's Signature A. Apa	Med			
	Registr	ar	JAN U O ZUUS KENOW JO. 1900	-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. Ng? [] [] 9 2. Date of Death 1, Decedent's Name (First, Middle, Last) **Physician** EWIS NORMAN 9:55 AM MILLER 2009 Jan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7593 BRAEMAR COURT CARROLL SYKESVILLE Birthplace (State or Foreign Country) 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X**M 2□F Months Days Hours 574-68-1028 OCT 11 **Director** WEST VIRGINIA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f shov notified at 1 XYes 2 No Funeral Director SYKESVILLE MO CARROLL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be r 21784 BRAEMAR COURT USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Yes 2 No 1971-If Yes, Give Year or Dates: 191< 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE þ 3 Widowed 4 Divorced 'natural". Completed other than "natur 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) MANTECH College (1-4or 5+) Elementary/Secondary (0-12) MECHANICAL ENGINEER INTERNATIONAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MILLER NORMAN, SR. 7 Is marked traumatic e MARTHA LEWIS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health MEGGY J. NORMAN 7593 BRAEMARCOURT, SYKESULLE MO 21784 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/6/2009 4 □ Donation 5 □ Other (Specify) South Carroll Cren. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JN ZUMBWN FHA MON Co Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ELDERSBURG MO 21784 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** una Concer months Trail /Medical Due to (or as a consequence of) Examiner Se mentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) burial-1 physician the burial Box 68760. Physician/Medical as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ò 1 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 2 1 Yes 2 No 4 Nursing Home 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 □ Yes 2 □ No Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year)

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

nmer

82. Registrar's Signature

Juliek. B

31. Date filed (Month, Day, Year)

JAN 0 5 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND, ITEM#20c, perFH, G887, 1/6/09 WS
State of Maryland, Department of Health and Mental Hygiene
1 #20b&c Per FH G887 1/12/09 JH
Certificate of Death
Reg. No. 200 amend #20b&c Reg. No. 2009 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician MICHELIN OKUDZETO JANUARY 2009 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CHEVERLY

Under 1 Year | If Under 24 Hrs. PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours Min. 1 X M 2 □ F Yrs NOV. 17, **GHANA** Director 1980 578-23-6174 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the M∞ical Examiner in ust be notified at 1 X Yes 2 ☐ No **Funeral Director** 28a-f DC WASHINGTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 2330 GOOD HOPE RD, SE #412 20020 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2 No If Yes, Give 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No <u>۾</u> Specify: 3 Widowed 4 Divorced Year or Dates: BLACK Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) LANDSCAPER/MAINTENANCE PRIVATE 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Health and Mental tem 27 is marked o THEOPHILUS OKUDZETO AMBERA KHADI မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MARY OKUDZETO / MOTHER 2330 GOOD HOPE RD, SE #412 WASHINGTON, DC 20020 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I-Important: If Ite any injury or oth Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Washington National 1/10/2009 Suitland, MD 21. Signatury of Funderal Service Lice 22. Name and Address of Facility MARSHALL S FUNERAL HOME OF MD 4308 SUITLAND ROAD SUITLAND, MD GRAY DONALD R. 23a. Part Enter the disease, of conshook, or heart failure. List of y plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Complications disease or condition resulting in death) /Medical Due to (r as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2- No 1 ☐ Yes 1 ☐ Yes Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other; 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA oţ 28a. Date of Injury
(Month, Day, Year) 28d. Describe how jajury occurred DMIV'S 27. Manner of Death 28b. Time of Injury Division 5 Pending investigation 1 Natural contro 4 Car 0419M 1 ☐ Yes 2 No after death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) at filled in by determined 4 Homicide Pennsy STreet WASH varen Avenue 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 HOSPITAL DRIVE, CHEVERLY, MD 20784 SALVADOR SYLVESTER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State IAN 06 Registrar 2009

State of Maryland / Department of Health and Mental Hygiene 20 00098 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Year **Physician** Jamuary 1, Goldie Alverta Oakman 9am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard 2827 Quail Creek Court Ellicott City If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, July 13, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 1920 **Funeral** 1 □ M 2 ₽ F Months MD 218-36-5124 88 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at MD **Baltimore** Windsor Mill 1 ☐ Yes 2 ĀNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with t and Mental Hygiene. is marked other than "natural", or items 23a or i 7016 Gaymount Road 21244 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 ☐ XNo Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 XNo Specify. þ If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Galligher Myrtle Twigg ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sl ment of Health an 7016 Gaymount Road Windsor Mill, MD 21244 Mr. Carlton Oakman (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) :1/5/2009 Woodlawn Cemetery Woodlawn, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PO Box 195 Sykesville, MD 2178 M00764 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final WRE-TO T Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence or). or Attending Physician: The law requires that the death certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of): signed by the attending physician a signed by the burial Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 9 ☐ Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by iosdevotra condiovasa 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🌠 Unknown been 24a. Was an autopsy performe 1 □Yes 24b. Were autopsy findings available prior to completion of cause of death? has this certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To nours after death.

neral Director: After this

filled in by the funeral d 28a. Date of Injury (Month, Day, Year) 28b. Time of 27 Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 23a) (Type, Print) Towsaltown

Registrar DHMH 17 Rev 1/2001

State

strar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 1 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** , 2009 Elizabeth Puleo January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Baltimore Timonium If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 😾 F Director 075-28-8863 17, 1933 New York Usual Residence of Decedent 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Even instructional by nothing at Director 1 ☐ Yes 21 No Maryland Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1420 W. Joppa Road Funeral 21204 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. em 27 is marked other than "natural", or itel 1 Never Married 2 Married 1 □Yes 2 😾 No Specify 2 Specify: White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 n/a Librarian Engineering Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Arthur Nolan Elizabeth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Keefe/Daughter 10 Pikehall Place, Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of 1 ☐ Burial 2 🖫 Cremation 3 ☐ Removal from State 4 □ Donation 5 Other (Specify) 1/2/09 Atlantic Crematory Glen Burnie, Maryland 22. Name and Address of Facility Funeral Service Licensee Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 23a. Part 1. Exer the disease, or complications the caused shock, or heart fail ire. List only one cause on each line Approximate Interval Between Onset and Death le death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Jause (Fine disease or condition resulting in death) **Physician** LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 **X** No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Was autopsy performed? 24a. Was an 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE Hospital: 1 ☐ Yes 2 🛣 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely oneX Nurse Practitionerner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 JONES, 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 Year) State

DHMH 17 Rev 1/200

Registrar

ANUARY

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Arthur Nathaniel Rogers, III TAN 2009 10:45 4a. Facility Name (If not institution, give street and number) 712 E. Seminary Avenue 4b. City, Town, or Location of Death TOWSON 4c. County of Death Baltimore 9. Birthplace *(State or Foreign Country)* Balt., Maryland Date of Birth (Month, Day, Year) 6/30/1941 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Days Hours Months 1**X** M 2 □ F 67 217-38-968 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Maryland Towson 1 ☐ Yes 2 ☐ No 10f. Zip Code 10g Citizen of What Country? United States of America 10e Street and Number 712 E. Seminary Avenue 21286 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status 1 ∑∑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2√2No Specify Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) United States Elementary/Secondary (0112) Captain Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arthur Nathaniel Rogers, II Amelia Braxton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12508 Catalina Drive Lusby, Maryland 20657 Kristina B. Opheim/ daughter 20b. Place of Disposition (Name of Evantery, Function of other place)

EVALUS FULCIAL Chapel - Bel Air 20a. Method of Disposition 20c. Location - City or Town, State January 1 ☐ Burial 2 ☼ Čremation 3 ☐ Removal from State Forest Hill, Maryland 4 Donation 5 DOther (Specify) 2009 22. Name and Address of Facility
Peaceful Alternatives Funeral
2325 York Road Timonium, 21. Signature of Puneral Service Licensee &Cremation Ctr., P.A. Maryland 21093 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) +hapertensive Cardiovascular years Due to (or as a consequence of): sentension Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) D'abe tes Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy performed? Yes 22 No 1 ☐ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Examiner Attending Physician: The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760, the attending physician as signed by should be been has certificate this After after death Director: filled in by the Hospital or A 24 hours after

Examiner Physician/Medical þ Completed Be Certification: To 124 hours a Medical To the within 2

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after

permit. Pages 1 and 2 should be filed 1 Department of Heath and Mental Hygin Important: If item 27 is marked other i any Injury or other traumatic event. In

Physician

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Itimore,

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Director

Funeral

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Completed

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State Registrar 29a. Certifier (Check only one)

FREDFILLE 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29c. License number

1711050500

STRUCT

BAITIMONE

29d. Date signed (Month, Day, Year)

MARY LAND

21201

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KOT

B.

JAN O

mo

32. Pegistrar's Signature

NONTH

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-00047 State of Maryland / Department of Health and Mental Hygiene Steven Michael Resnick <u> 2009 0010</u>1 Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month January 2, 2009 1254 hrs Medical Examiner Steven Michael Resnick 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Lutherville Timonium 5 Lincoln Street g. Birthplace (State or Nary Land 5. Social Security Number 212-50-3148 Date of Birth (MM/DD/YYYY If Under 1 Year If Under 24Hrs: 7. Age (In yrs: last birthday) **Funeral** August 21, Min Months Days Hours 49 Country) Director 1959 1X M 2 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No Maryland Baltimore Timonium 28a-f show notified at once. 10f. Zip Code 10g, Citizen of What Country? United States 10e. Street and Number 5 Lincoln Street 21093 of America or items 23a or 14. Race - American Indian, Black, . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 11 Marital Status t. Pages 1 and 2 should be filed within 72 hours after death wit trent of Health and Mehal Hygien.

reaut: If tiem 27 is marked other than "natural", or items 3
or other trainmatic event, the Medical Examirer must be 1 Armed Forces' 2 X Married Never Married X No Yes Specify: white Yes 2 X No specify: If Yes, Give Year Widowed Divorced ò 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Defense Contractor 12 Master Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Burton Stanley Resnick Marlene F. Kaufman Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5 Lincoln Street Timonium, Maryland 21093 N N Darlene L. Resnick/ wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition January Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 7, 2009 Druid Ridge Cemetery Baltimore, Maryland Donation 5 Other Specify: 2. Name and Address of Facility eaceful Alternatives Funeral & Cremation 2325 York Road Timonium, Maryland 21. Signature of Funeral Service Licensee Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Me dical Death Narcotic (methadone) intoxication Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner Lause. Enter Universitying Couse (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit The law requires that the death certificate be executed AMENDED 23a,27,28a-f,perME, g888 2/6/09 TT Physician/Medical X UNPENDED attending physician or use as the burial Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Ö Part II. Other significant conditions Yes 2 No 3 Probably 4 V Unknown ð Division of Vital Records, P. Completed should i 24a. Was **a**n 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has il director, page 2 s' performed? death? Yes Yes 2 1 1 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be Other4 examiner? Hospital: Residence 6 V Other: Scene Nursing Home 5 Inpatient ER/Outpatient 3 DOA ۲ 1 Yes 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work 28a. Date of Injury (Month, Day, Year After 27. Manner of Death Certification: Yes 2 X No unk Natural Pending Fd 12:50 Funeral Director: stely filled in by the 1/2/2009 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5 Lincoln St Lutherville, MD28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide residence determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie **OCME** January 3, 2009 O,C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. 3. Registrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 00102 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day 6.04 Ам mes January 2009 ODer Oans /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memoria Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Hours Min Director Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "modeal Eventher must be notified at Director 1XYes 2 □ No MO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Year or Dates: Vac Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AMER permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ nae 9a. Informant's Name/Relationship (Type. Print) 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Battimore, HD 2121 2 arcelette 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 12 Surial 2 ☐ Cremation 3 ☐ Removal from State Signature of Euneral Service Licensee Arbutus MD lemorialtark 22. Name and Address of Facility Phillip A. more, HD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** days NSTEMI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed Sep 313 and Due to (or as a consequence of): burial-1 physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy the Hospital or Attending Physician: The this certificate 2 No 1 ☐ Yes 2 🔽 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ After thi funeral (Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury ithin 24 hours after death.

the Funeral Director: A smpletely filled in by the fu 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

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Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Records,

Division of Vital

'n

Registrar

Medical

31. Date filed (Month, Day, State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

06 2009

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

AT 2438946

29d. Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygien

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	Sta Registr	te	31. Date filed (Month, Day, Year)	33, Registrar's Sign	ature (12 Mars						1 - 74 5 1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

			For State Registrar	State of Mary	yland /	Cer.	nment of H tificate of L	eaim and i Death	wental Hyg	Reg. No. 2009	00104
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	Examin	er	Keswick Multi Ca					imore		N/A	
e.	Funeral Director		5. Social Security Number 6. Social Security Number 1 6. S	ex 7. Age (III	n yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May 31,	9. B 1924 M	irthplace (State or Foreign Country) laryland
ight (file	D		Usual Residence of Decedent 10a, State 10b. County	10	Oc. City, To	own or Loc	ation		inay or,	232.	10d. Inside City Limits
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5-0036	be filed within 72 hours after death with the Maryland of blygiene. All hygiene. do thygiene. do ther than "natural"; or items 23a or 28a-f show there than "natural"; or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	3 Widowed 4 Divorced	1 Mes 2 No If Yes, Give 1944 Year or Dates	-	!	Yes 2 No	Specify:			White
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Maryland 2	be be eve	Be	17. Father's Name (First, Middle, Last)		oeh1				ne <i>(First, Middle, .</i> Mary	Maiden Surname) Gorschbo	nth
37	shou ind M imar umat	၉	Henry 19a. Informant's Name/Relationship (1)			9b. Mailing	g Address (Street a			r, City or Town, State,	
	is 1 and 2 of Health a ltem 27 is other trai		Norma Roehl	Wife			Loch Hil			ore, Maryl	
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T T			4 ☐ Donation 5 ☐ Other (Specify 21. Single re of Futeral Service Licen		<u>Hillt</u>		ervice Co			Towson	Maryland
Ba	permit. Depart Import any Inj			dan			1050 York				1 Home, Inc. 21204
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the one cause on each line.	e death. D	o not ente	r the mode of dyin	g, such as cardia	c or respiratory arr	rest,	Approximate Interval Between Onset and Death
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Box	death certifi attending for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	∃ Fetal dea		Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
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	To the Hospital or Attending Physician: within 44 hours dater death. To the Funeral Director: After this certifica completely filled in by the funeral director, it		(Check only 2 Medical Exam	ysician: To the best of miner: On the basis of ex	ny knowled	lge, death and/or inv	occurred at the tin	ne, date and place	e, and due to the durred at the time, d	cause(s) and manner a	as stated. ue to the cause(s)
	o the vithin 2 or the l	Medical	29b. Signature and title of certifier	and manner stated			29c. License			29d. Date signed (Mor	
	r > F 0		or Babelle Ma	& gregor	eno		Di3	657		Tannary 2	, 2009
_	1641		30. Name and address of person who	completed cause of death	h (Item 23a	a) (Type, F	Print) Who STRE	ET, BAL			
	Sta Registr		31. Date filed (Month, Day, Year)	32. Pegistrar's							

			For State Registrar	State of M	aryland		artment of He tificate of L		lental Hy	/giene .Reg. No.	2009	00105
			Decedent's Name (First, Middle,	Last)					2. Date of Do		Year	3. Time of Death
	Physici: /Medic					Smith			1	3	2009	10:30 ^{A_M}
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	Funeral		Future Care 5. Social Security Number 6		je (In yrs. la	ast birthday)		If Under 24 Hrs.	8. Date of Bi	rth	N/A 9. Birth	nplace (State or Foreign
ľ	Funeral Director		243-48-6254	1□M 2KSF	83	Yrs.	Months Days	Hours Min.	(Month, D) 4-16	5-19	25	N.C.
	pus *		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
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	r 28a	Director	10e. Street and Number				10f. Zip Code					untry?
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heath and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23s or 28s-1 show any injury or other traumatic event, the Madical Examiner must be notified at Once.	by Funeral	11. Marital Status 1 Never Married 2 Married Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 Yes 2 If Yes, Give Year or Dates:)		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 🌠 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)		14. Race - Amer Black, White Specify: B	
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and	2 sho		19a. Informant's Name/Relationship	(Type, Print)			ng Address (Street a			ber, City o	r Town, State, Zi	ip Code)
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	ages nt of H t: If ite		XXBuriai 2 ☐ Cremation 3		CE	emetery, crei	natory or other place	9)				
altimore,	entre Prortan		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li		_ K1	-	emorial R. Name and Addres		arch I		dallst F/H	OWII, FID
ä	Dep in p		> Blade	e Wan	حرو		1101 E.					D 21202
l			23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that cause by one cause on each I	d the death ine.	. Do not ent	er the mode of dying	g, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
Ħ	Physician		Immediate Cause (Final disease or condition resulting in death)			NYOP	YHTA					くんくつい
ſ	/Medical Examiner			Due to (or as		11	EART	Fai lure				Unknown
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4	icate be executed physicien and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с.								
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687		edical		d								
P.O. Box	The law requires that the death certifi ate has been signed by the ettending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)			2	23d. Date of deli Month	very Day Year
	res that igned b be deta	by Pł	Part II. Other significant condition	_	out not resu	ılting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco u	ise contribute to	the cause of death?
ord	w require been sig should b		HYPERTENS						1 🗆	Yes 2	□No 3□Pro	bably 4 🗹 Unknown
Division of Vital Records,	ding Physician: The law i h. After this certificate has bi funeral director, page 2 sh	Completed	DIABETES	s an opsy formed? 2 No								
Ĕ	siciar certif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati	not 2 🗆	ER/Outpatier	nt 3 DOA Othe	26. Place of Deat			6 □Other (Spec	
o	g Phy er this eral d	\vdash	27. Mann of Death	28a. Date of Inj (Month, Da	urv	28b. Time o Injury			28d. Describe			ny)
ior	Attending Physician: r death. ector: After this certifice by the funeral director, f	atlo	1 Yatural 5 Pending 2 Accident investiga	tion	.y 70di/	Injury		res 2 □No				
ž	or Att efter de Direct in by t	Certification;	3 Suicide 6 Could no 4 Homicide determin	ed 286. Place of in	jury - At ho tc. (Specify		eet, factory, office			(Street and own, State		ral Route Number,
	To the Hospital or Attan within 24 hours effer deat To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best caminar: On the basis and manner s	of examinat	wiedge, deat ion and/or in	h occurred at the tim vestigation, in my op	e, date and place, pinion, death occur	and due to the red at the time	cause(s) , date and	and manner as I place, and due	stated. to the cause(s)
	To the Within To the compl	Me	29b Signature and title of confiler				29c. License	number		29d. Dat	e signed (Month	, Day, Year)
			119	2			Doc	259056	>	11	4/09	
	3			uia MD		3612	- Falls 1	rz B	cit M	0	2121	١
	Sta Registi		31. Date filed (Month, Day, Year) JAN 0 6 2009	Seren 32. Regist	rar's Signa	park	1					

Registrar DHMH 17 Rev 1/2001

	1	For State Registrar	Please			and / De	partment of ertificate of	Health	and Me	ental Hy		gible.	0010
Physician /Medical		Decedent's Name (F	SYL	LIVAN	rembo v)		4b. City, Town,		2	Date of De Month Jan	ath Day	Year 2009	3. Time of Death
Examine	4	a. Facility Name (If no Iniversity Social Security Numb	of man	gland m	edical a	ienter	Balti	more	-	. Date of Bir		nty of Death	place (State or Foreign
Funeral Director		574-24-324 sual Residence of De	7 1	□M 2 X F	46	Yrs	Months Day			SEP 9 Da	1962	Alas	ka
Maryland a-f show			b. County Baltim	ore		City, Town or Baltim							0d. Inside City Limits 1 ☐ Yes 2 No
tter death with the Mar tritems 23a or 28a-f si the rest be ruffled	11	oe. Street and Numbe		s Road		_	10f. Zip Code 2122				10g. Citizen o	of What Cour USA	ntry?
S as a s	2	1. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☐		12. Was Dec Armed Fo 1 ☐ Yes If Yes, G Year or D	orces? 2 X No ive	1 U.S. 1	3. Was Decedent of If Yes, specify Cu			ify Yes or No can, etc.)		tace - Americ lack, White, cify: Whi	etc.
ed within 72 houygiene.	- bleten	15 (Specify of Elementary/Seconda	Decedent's Econly highest gra	ducation ade completed) College (1-4or 5+)	(G life	ecedent's Usual Occ ive kind of work dor e. DO NOT use reti	e during mo	st of working		16b. Kind of		dustry
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od 2 should but and Men 27 is marker traumatic		9a. Informant's Name aniel F. S	Relationship (Type. Print) h U	sband		ailing Address <i>(Stre</i>	et and Num	ber or Rural i		•		
Pages 1 an nent of Hea nt: If item 2	2	0a. Method of Disposi 1 □ Burial 2 □ C 4 □ Donation 5 □	remation 3		State Me	b. Place of Dis	sposition (Name of crematory or other p	lace)	Dat	te	20c. Locatio	n - City or To	own, State
permit, Departm Importa any inju	2	1. Signature of Funer			iams		Name and Add MacNabb 301 Fred					. MD	21228
Physician /Medical	1	23a. Part 1. Enter the c shock, or heart fa mmediate Cause (Fin disease or condition esulting in death)	allure. List only	a. SE	PS15	eath. Do not							Approximate Interval Between Onset and Death A Days
attending physician and artending by a physician and artending by a physician artending by a physici	ָלֵם רְי	sequentially list conditions, any, leading to immerause. Enter Underlyin ause. (Disease or injuration intait intiated events esulting in death) Last	ions, diate ng iry	C		sequence of):							
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the Modical Certification. To Be Completed by Divesirian Madical	yaiciai iriica	F FEMALE: 3b. Was decedent pre in the past 12 mo 1 Yes 2 No 9 Value of the past 12 No	nths?		birth 2 🗆 F nant at time	etal death	3 ☐ Ectopic pregna 5 ☐ Other (specify)					Date of deliv Month	ery Day Year
requires that the debeen signed by the should be detached	רַ בּ	art II. Other significe	nt conditions	ontributing to c	leath but not	resulting in the	e underlying cause	given in Part	II.		obacco use co		he cause of death?
The law require cate has been signed by page 2 should by										24a. Was autoj perfo 1 ∐Yes			ppsy findings available impletion of cause of 2 \(\sum \) No
hysiclan: this certifical director,	2	25. Was case referred to medical examiner? 26. Place of Death (Check only one)										Other (Speci	(y)
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ital or Attending P rs after death. ral Director: After ited in by the funera									Street and Nu wn, State)	Street and Number or Rural Route Number, wn, State)			
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	מחוכם			miner: On the			eath occurred at the or investigation, in m						
To t To t com	2	9b. Signature and title	e of certifier		S			anse number	1378		JAN.		
4	1	0. Name and address	Source	sine "	10 2	2 50	pe, Print) OTH GRE	ENE	STR	EET, I	BALTIN	IORE M	D 21201
State Registra		1. Date filed (Month, I	Day, Year) 1 U 6 20(19 Jan	Registrar's Si	gnature A.	arked						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 5:04 AM 50 ANUAR 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number Examiner Memorial If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours Min 216-02-7326 1 □ M 2 🗙 F 06/09/1966 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Exprisiner rust by notified at 1 X es 2 □ No by Funeral Director Himore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Department of Health and Mental Hygiene in the 27 is marked other than "natural", or items 23a or any Injury or other traumatic event. The Merican Experiments 23a or any Injury or other traumatic event. USA 21229 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disability Sabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Avenue Battimore, MD. 21205 tather 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State Baltimore 01 09 09 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Phill, PA. Weatherford Funeral Services P.A. 2431 E. Oliver Street Baltimore, Maryland 21213 Approximate Interval Between Onset and Death Part 1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) IEPRS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. Physician/Medical as the IF FEMALE: cate has been signed by the attendir page 2 should be detached for use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 3 Probably 4 → nknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate 2 100 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural Iniury 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 6 2009

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** BETTY J. **SMITH** 7:50 HM January 05 2009 /Medical 4c. County of Death 4a_Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltenuce washington Medical Burnie Glen ANNE ARUNDEL 8. Date of Birth Sept . 23, 1936 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months Min 1 □ M 2 1 F Maryland 212-34-8651 72 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov in Jury or other traumatic event, Ins. Medical Examiner must be notified at 1 □Yes 2 No Director Maryland Glen Burnie Anne Arundel 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21060 U.S.A. 5 Normandy Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 2 should be filed with and Mental Hygier7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be L. Bedell Rvland Winifred George ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and Department of Health ar Important: If item 27 is James C. Smith Jr. 5 Normandy Drive, Glen Burnie, Maryland 21060 (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 01-08-09 Brooklyn Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ,22 Narge and Address of Facility McCully—Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 21. Signature of Funeral-Service Licensee Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final ASD: NATION **Physician** PNUMB NIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner OBSTRUCTIVE LUNG DISCHSE 3xACCD23ADon OF (UIZON:C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed MYPONHT & GMiA and burial-tra Due to (or as a consequence of): physician the burial Box 68760. Physician/Medical use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. signed by the a 9 D Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s been signal Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an las page 2 certificate I funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural s after death.

I Director: Af in by the fur 1 □Yes 2 □ No 2 Accident ☐Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide ö within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar

State

29b. Signature and title of certified

SALDMOLE

31. Date filed (Month, Day, Year)

JAN 0 6 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WAS11.26702

32. Registrar's Signature

0

MEDICAL

29c. License number

CONTER

703

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Farl Sturgill Jr. Lester January 04 2009 5:10 A 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel County Glen Burnie Rehab. Center Glen Burnie If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, April 23, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, Days Hours Months 1 M 2 □ F 1935 Virginia 217-32-8009 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 Yes 2 No Baltimore Maryland N/A 10g. Citizen of What Country? 10f, Zip Code 10e Street and Number U.S.A. 21226 4204 Fairhaven Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 🔣 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Printing Industry Elementary/Secondary (0-12) Printer 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lester Earl Sturgill Sr. Ruth E. Neighbors 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4204 Fairhaven Avenue, Baltimore, Maryland 21226 Mary Strugill (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 01-06-09 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Edneral Service Lice McCully-Polyniak Funeral Home P.A. 237 Fast Patapsco Avenue, Baltimore, Maryland 21225 Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IE FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Year 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2₽No 1 □Yes 2 □No 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred

Box 68760, P.O. I Division of Vital Records,

be executed the burial-trans. and attending physician use as for the a detached cate has been signed by page 2 should be detach certificate has funeral director, this To the Hospital or Attending Pr. within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral

Physician/Medical 2 Completed Be Certification: To

Examiner

Medical

Physician

/Medical

Director

Funeral

ð

Completed

Examiner

Funeral

Director

? Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Evandinatary up to Indiffed 21

72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than '

Department of Health ar Important: If Item 27 Is any injury or other trau

Physician

/Medical

Examiner

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

31. Date filed (Month, Day,

State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

5 Pending investigation

6 Could not be determined

Year

JAN 06

29b. Signature and title of certifier

Mame and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

			FOI	partment of Health and Me	ental Hygier	ne	
			1103101141	ertificate of Death	Reg. N	10.2009	
	Physici	an	1. Decedent's Name (First, Middle, Last)	2		Day Year	3. Time of Death
and the same of	/Medic	al	Joe	Smith		14 2009	11:52 PM
	Examin	er	4a. Facility Name (If not institution, give street and number) 1	4b. City, Town, or Location of Death Baltimore		ic. County of Death Belli Mor	0
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		8. Date of Birth (Month, Day, Yea		place (State or Foreign
į.	Director		307-34-7254 1⊠M 2□ F 74 Yrs.	Months Days Hours Min.	(Month, Day, Yea 10/10/19:	34 Cou	ntry) KY
	pui »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L				101 1 1 1 0 1 1 1
	f shor	ō					10d. Inside City Limits 1 No 2 No
	the N	Director	MD Arme Arundel Glen E	10f. Zip Code	100.0	Citizen of What Cou	
	3a or		109 Bonnie View Road	21060		J.S.A.	y.
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R		14. Race - Ameri	
9	or ite		1 Never Married 2 Married 1 Yes 2 No 1934	1 ☐ Yes 2 ☑ No Specify:	lican, etc.)	Black, White,	
8	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examination at the colling at	d b	3 LF Wildowed 4 LI Divorced Year or Dates:				nite
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פ	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maide	en Surname)	
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Maryland 21215-0036	2 should and Men is marke aumatic	i b		ling Address (Street and Number or Rural			
	1 and 2 Health em 27 i			Bonnie View Road /			
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	1 10	I La Buriai 2 Li Cremation 3 Li Removal from State I	ematory or other place)		Location - City or To	own, State
≣	utt. Partmentant			nard Cemetery 1/10/2		berty, KY	
Ba	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Sing Services; 1 2nd Ave	Leton Fur	ieral & Ci	remation
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	Physician	6.3	shock, or heart failure. List only one cause on each line. immediate Cause (Final	h to		·	Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as "consequence of):	apar jar			
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	ificate g phy as the	edical	d.				
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<u>Ч</u>	at the I by the	hys	9 Li Unknown				
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36	has l	Completed			24a. Was an autopsy	prior to co	ppsy findings available mpletion of cause of
Vital Records,	n: Th fficate or, pag		25 Was seen referred to a disci		performed?	death? 1 ☐ Yes	2 🖃 No
5	ding Physician: The faw h. After this certificate has funeral director, page 2 &	e Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ ₩0 Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatie	26. Place of Death (
ō	g Phy er this	Ë	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28	e 5 Residence 3d. Describe how inj		(y)
Ö	ath. r: Aff	atio	1 ☐ Natural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation	Work? 1 ☐ Yes 2 ☐ No			
Division of	r Atte	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s' building, etc. (Specify)	treet, factory, office 28	3f. Location (Street a	and Number or Rura	al Route Number,
	urs aft ral DI					,	
1	To the Hospital or Attending Physician: The faw requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) 2□ Medical Examiner: On the basis of my knowledge, dead control one) and manner stated and manner stated.	ath occurred at the time, date and place, an investigation, in my opinion, death occurred	nd due to the cause d at the time, date a	e(s) and manner as a and place, and due to	stated. o the cause(s)
)	o the	Mec	29b. Signature and Mattle of certifier	29c. License number	29d. D	Date signed (Month,	Dav. Year)
	F > F 0		Yang shund	RESODO		n,04,	2009
	12		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)		,, , (/	
_	31		Yasir Hamad 3001 S. Ham	oner St, Bal	timone	MO. 2	225
j	Sta		31. Date filed (Month, Day, Year) JAN U6 2009 32. Registrar's Signature	he del			
	Registr	ar	JAN 0 0 2003 Acres 12. 1	p auro			

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Year Month Fred Morris Southerland 3:53 A M January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3005 Regina Drive Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days Hours 9, 83 Texas 466-26-8791 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code **USA** 20906 3005 Regina Drive 12. Was Decedent Ever in U.S. Armed Forces? 1X1Yes 2 □ No 1fYes, Give Year or Dates:1943-46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify:White 1 ☐ Yes 2X No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Professor University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lora Sawyer Earl Southerland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3005 Regina Dr. Silver Spring, MD 20906 Elaine L. Southerland/wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Fernation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date W. Arundel Crematory 01/03/09 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) Coing Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 21. Signature of Funeral Service Licensee Heve TE MO1251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
6 months Immediate Cause (Final Transitional Cell Carcinoma disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atherosclerotic Cardiovascular Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Xio 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D. 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Miller GATY January 2, 2009 D13325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Gary H. Miller, M.D. 2440 M Street NW Suite 810 Washington, D.C. 20037 2011 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Month **Physician** 2, 9:20 АМ January Seifert William /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist @ GBMC Baltimore Towson If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 216–20–3786 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) **Funeral** Vaar Days Hours 1 M 2 □ F Months Min. 83 March 15, 1925 Maryland Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a State 10h County s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental hygiene with the 12 for after dead other than "natural", or items 23a or 28a-f show other traumatic event, it is "Model Eventine" was the natified at 1 □ Yes 🏋 No Director Dundalk Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 USA 8123 Midhaven Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Clerical Steel 12 years permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyol Important: If item 27 is marked any injury or other *** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ella Florence Seitz Carl William Seifert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bertha Seifert wife 8123 Midhaven Road, Dundalk, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition January 5, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cardens of Faith Cemetery Rosedale, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Phermonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (usaas or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Ye ar 5 ☐ Other (specify) 2 □No Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 DONO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 Arother (Specify) (100) (7) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

Jason Blac

31. Date filed (Month, Day, Year)

JAN 05

Charles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565

1

North

32. Registrar's Signature

D0061199

Suite 209 Touson MB 21204

Sonnie Lou Smith		For State	State	e of Ma	ryland /		rtment of tificate of			Menta		Re	eg. No.	20		0011
Physician/ Medical Examine	1	. Decedent's Name									- N	ate of Deat nonth anuary 1	Day	Year		ne of Death 027 hrs
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Funeral	5	1731 Winar		Sex	7. Ag	e (In vrs. la	ast birthday)	Halet	norpe er 1 Year	If Under	24Hrs: 8.	Date of Bir		(ITTOTE CO		e (State or
Funeral Director	- 1	219-74-76		M 2X		44	Yrs	Month		Hours	1.4	/7/19	64		eign Country)	MD
any	-	Isual Residence of 0a. State	f Decedent 10b. County			10c. City,	Town or Locati	ion							10d.	Inside City Limits
* .	, M	1 D	Baltimo	re		Hale	thorpe									Yes 2 X No
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r death with or items 23 must be no		Never Marn		ed Arm 1 \ \ ed If Yes, Giv		X No		·	X No		Puerto Rica	an, etc.)	Si	White, etc	nite	
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21215-0036 suld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	3 K	Kenneth K		(Type Print			19b. Mailing	n Address			e Mi]		nber. City	or Town, St	ate. Zip (Code)
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Division of Vital Records, P.O. spital or Attending Physician: The law requires that thours after death. neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach.		3 Suicide 4 Homicide	6 Could determ	lot be	e. Place of I ec <i>ify)</i>	njury - At h neig	nome, farm, stre ghbor's	hous hous	y, office bi	ulding, etc	28	or Jown, Halet	State) State) horpe	o-7311 ^{per} W	inan	oute Number, City S AVe •
hou hou		29a. Certifier 1	Certifying Phy	sician: To ti	ne best of r	ny knowled	dge, death occu	rred at th	e time, da	te and place	ce, and du	e to the cau	ise(s) and	manner as	stated.	uee(e)
To the Its within 24 To the Francompletel		one) 2 🗸			nner stated		and/or investiga		opinion,		urred at th	ie time, date		ate signed		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 2:47 OSR 2009 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Medical Con HODKins timore view If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. October Sex ⊁ M 2 □ F Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign ^{Year)} 1939 Maryland 69 220-36-3349 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2√ No Balto. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5842 East Avenue 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? M⊒Yes 2 □ No If Yes, Give Year or Dates: AirForce Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 🏖 No Specify: White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Safety Chief U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances E. O'Connor Joseph O. Sheckells 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto. Md. 21206 <u>Louise Sheckells</u> Spouse 5842_East Avenue 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1-9-2009 Garrison Forest Owings Mills, Md. 4 ☐ Donation 5 ☐ Other (Specify) Schimunek Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 9705 Belair Rd. Nottingham, Md. 21236 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final B1000 disease or condition resulting in death) 0 Due to (or as a consequence of) for Sequentially list conditions, if any 1 ling 1 mm discause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Md.

Funeral

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination and once.

burial-trar attending physician for use as the burial s been signed be should be deta certificate has page

or Attending Physician: The law requires that the death certificate be executed After this certific funeral director, I ours after death. within 24 hours a completely

Division of Vital Records, P.O. Box 68760,

Oi

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Celler, MI

JAN 0 5 2009

Sam

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940

2. Registrar's Signature

IF FEMALE; 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fett 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 Ectopic		23d. Date of delivery Month Day Year
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				24a. Was an autopsy findings availal prior to completion of cause of death? 1 □ Yes 2 □ No 1 □ Yes 2 □ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatient 3 □ D	Othor	eath (Check only one) Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factor fy)	ry, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	/sician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occurred ation and/or investigation	d at the time, date and pla on, in my opinion, death oc	ce, and due to the cause(s) and manner as stated. scurred at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier		20	ac License number	29d Date signed (Month Day Year)

DHMH 17 Rev 1/2001

State

Registrar

9 STE

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 - For State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2009 2:00 Schroeder Erwin W. Januarv /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist 9. Birthplace (State or Foreign Country)
New Jersey If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5 Social Security Number 6 Sex **Funeral** Months Days Hours 1 🕅 M 2 🗆 F June 18,1916 92 145-09-3919 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a State 10b County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2XXNo Funeral Director Maryland Baltimore Towson 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21286 U.S.A. 7311 Knollwood Road hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 □Yes 2 No Specify: P A Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Home Inprovement al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Company 12 Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be file Health and Mental H Im 27 is marked oth Be Matilda Grams Schroeder Frederick 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21204 Health em 27 i Towson, <u>Mary</u>land Frederick A. Schroeder Son 535 Allegeheny Avenue 20b. Place of Disposition (Name of cemetery, crematory of other place)
Dulaney Valley
Memorial Gardens 20c. Location - City or Town, State Date 20a Method of Disposition Pages 1 Department of Important: If it any Injury or o 4 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify)

21. Signiture of unital environments 1-5-2009 Timonium Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MTERAL ecas Physician AMYOTROPHICIL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sele consequency off Examiner law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No ed by the a 9 TUnknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by DYSPHAGIA 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy performed certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Natural 2 Accident 5 Pending investigation I hours after death. uneral Director: Aft ely filled in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours after

To the Funeral Direct

completely filled in by Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Towsateur Blud/Balto MD 9 -raulkner MD 31. Date filed (Month, Day, Year) 32. Registrar's JAN 0 5 2009 Registrar

020

21215-0036

Maryland

Baltimore.

Box 68760

P.O. |

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2009 6:30 a January Tait Andrea M. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Towson **Baltimore** Gilchrist Center for Hospice Care If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** oCT 9 1956 Months Days Hours ILIM 2XF New Jersey 52 184-44-3089 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show item 27 marked other than "natural", or items 23a or 28a-f show other traumatic event, the added Eventing Funds to Julian an 1 ☐ Yes 2 ☐ No Catonsville Director Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21228 3 N. Symington Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) n and Mental Hygiene. College (1-4or 5+) Musician Fine Arts 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be fi Mental F. Petak Veronica . Pages 1 and 2 should be ment of Health and Ment tant: If item 27 Is marked Andrew Tait 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3 N. Symington Avenue, Catonsville, MD 21228 Franklin Tait - brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department or Important: If any injury or Metro Crematory, Inc.01/02/2009 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funers Service License Williams Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD_ 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Year.(disease or condition resulting in death) Mnaxic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Each of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 🖼 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, s after death.

I Director: A in by the fu within 24 hours a

To the Funeral C

completely filled

Baltimore, Maryland 21215-0036

Registrar

31. Date filed (Month, Day, Year) State

29a, Certifie

(Check only

29b. Signature and title of certifier

and manner stated.

29c. License number

00061199

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Suite 209, Touson, MB 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6563

32. Registrar's Signature

			For State		State	of Marylan		artment of F r <i>tificate of I</i>			~ ~	0.0	00110
			1. Decedent's Nam	e (First, Middl	e. Last)			imodic or i		2. Date of Dea	th No.2	113	3. Time of Death
	Physicia		Leida	Tamm	1 77					January	7 1 200	Year Q	9:40 a M
	/Medic		4a. Facility Name (number)		4b. City, Town, or	Location of Deat		4c. County		J. 10 G
			Stella	Maris				Timoni			Balt		
	Funeral		5. Social Security N		6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day	(Year)	Coun	
	Director		222-36-0 Usual Residence of			84	115.			MAR 28	1924	Esto	nia
/land	A H		10a. State	10b. County		10c. Cit	y, Town or Lo	cation				10	od. Inside City Limits
Mar	a-f s-f	ctor	MD	Balti	more	Ca	tonsvi	11e					1 ☐ Yes 2 No
aryland 21215-0036 should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: yor items 23a or 28a-f show Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Medical Evantral must be notified at once.	Funeral Director	10e. Street and Nu 6348 Fre		Pood			10f. Zip Code 21228		.1	log. Citizen of V		try?
ath w	s 23a	eral		edet fck		andost Francia III	6 142		lianania Origin? (6	Precify Vac or No.		e - Americ	an Indian
ter de	item	Fundal	 Marital Status Never Mari 	ied 2□ Mar	Armed	ecedent Ever in U Forces? s 2 K No	.5.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)		k, White, e	
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iled w	Hygie ther ti	S	17. Father's Name	/First Middla	l aet)		Homem	aker	18 Mother's Na	me (First, Middle,	Own Ho		
and dbe f	ental l red of) Be		Rohulai	•				Marie	Peit		-,	
Maryland 21215-0036	mark mark	은	19a. Informant's N	ame/Relations	ship (Type. Print)		19b. Maili	ng Address (Street	and Number or R	ural Route Numbe	r, City or Town,	State, Zip	Code)
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ore,	of Her Item		20a. Method of Dis	1			Place of Dispo	sition (Name of natory or other place	ce)	Date	20c. Location -	City or To	wn, State
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Baltimore, permit. Pages 1 av	eparti nporti ny inj nce.		21. Signature of F	uneral Service Stev	Licensee en H. Wi	11iams	2:	MacNabb I 301 Frede	ss of Facility uneral I	Home, P.A	١.		
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J. that t	signed b d be deta	by Pł	Part II. Other sign	ificant conditi	ons contributing to	death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use cont	ribute to th	ne cause of death?
rds quires	should be				W					1 🗆 Y	es 2🗶 No	3☐ Prob	ably 4 Unknown
aw re	has been e 2 should	plet								24a. Was a			psy findings available mpletion of cause of
Vital Records, sician; The law requires the	cate hg	Completed								perfor 1 □ Yes	med?	death? 1 ∐Yes	
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of \	this o		1 Yes 2			Inpatient 2	ER/Outpatie		4 LI Nursing	Home 5 ☐ Resid		_ ` '	y) HOSPICE
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Ö.	Dire d in b	Certification: To	4 Homicide	deteri	bu	ilding, etc." (Speci	ty)			City or Tow	n, State)		
ospita	24 hours Funeral etely filled		29a. Certifier (Check only					th occurred at the ti					
Division To the Hospital or Attending	within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	one) X N	urse Pr	cactition	e basis of examining	ation and/or ii						
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16			30. Name and add	0.					MTMONTING	. MD 010			
14	Sta	ate_	JACKIE J) 32	O DULAN Begistrar's Sign	ature		TTMONTOM	, MD 210	7.5		
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Registrar DHMH 17 Rev 1/2001

JANUARY 1, 2009 9:40 a.m.

LEIDA TAMMER

		For State Registrar	Type or Prin AMEND ITE State of Ma	Miāna7 Đepa	G888 artment of the rtificate of	1091#Wand I	Mental Hy	giene	 19 NN 119
Physic		1. Decedent's Name (First, Middle, La James	J.		gliafer		2. Date of De Month January	ath Day	3. Time of Death
/Medi Exami		4a. Facility Name (If not institution, given 3716 Claremont St.			4b. City, Town, o	r Location of Death		4c. County of N/A	
Funeral Director		213-00-0550	Sex 7. Age	(In yrs. last birthday) 57 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Biri (Month, Da November	th y, Year) 18,1951 M	9. Birthplace (State or Foreign Country) Iaryland
: Maryland a-f show ified at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland N/A		10c. City, Town or Lo					10d. Inside City Limits 12 Yes 2 □ No
ath with the 23a or 28 ust be not	Funeral Director	10e. Street and Number 3716 Claremont Str	reet		10f. Zip Code 212	24		10g. Citizen of Wh	at Country?
BAITIMORE, IMARYIANG 21213-UU35 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item Z7 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Mouther Image must be notified at appear. any injury or other traumatic event, the Mouther Image must be notified at appear.	by Fune	11. Marital Status 1 ☐ Never Married 2 🌠 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Tyes 2 TN If Yes, Give Year or Dates:	0	Was Decedent of H If Yes, specify Cuba 1 □Yes 2 🖔 No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Pican, etc.)	Black,	- American Indian, White, etc. White
Z1Z15-UU36 d within 72 hours aff giene. er than "natural", or the Weddell Exami	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5-	(Give		during most of worl d)	İ	16b. Kind of Busi	·
land z Id be filed v lental Hygic ked other i ic event, m	To Be Co	12 years 17. Father's Name (First, Middle, Last James Tagliaferro	•	L L I	refrighte		e (First, Middle,	Baltimore Maiden Surname)	
, Maryland and 2 should be file salth and Mental Hy n 27 is marked oth er traumatic event	-	19a. Informant's Name/Relationship (Susan Tagliaferro	71			and Number or Ru t Street,			
Baltimore , oermit. Pages 1 au Department of Hez Important: If item any Injury or othe once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special		20b. Place of Dispo cemetery, cree Bayview C			ary 009	20c. Location - Co	
Depar Depar Impor any in		21. Signature of Funeral Service Lice	Con	elly '	7110 Soll	Funeral l lers Poin	t Road.	Dundalk.	P.A. MD 21222 Approximate
Physician /Medical		23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	.a. hela	consequence of):	luz car		or respiratory a	1631,	Interval Between Onset and Death
/60, te be executed exec	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	conse juence of j:					
BOX 08/0U, leath certificate be ex attending physician a for use as the burial-	Medical	IF FEMALE:	d						
F.O. BOX nat the death co d by the attend etached for use	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3 ☐	☐ Ectopic pregnanc ☐ Other (specify) _	cy .		23d. Date Monti	
w requires that the despension of the standard be detached to	by	Part II. Other significant conditions of	contributing to death bu	t not resulting in the u	nderlying cause giv	en in Part I.			ute to the cause of death? ☐ Probably 4 ☐ Unknown
VILAI MECC sician: The law re certificate has be rector, page 2 sho	Completed							sy priemed? dea	ere autopsy findings available or to completion of cause of ath? Yes 2 - No
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DIVISIO al or Attendi s after death, I Director: A	Certification: To	2 Accident Investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 290 Place of Injur	ry - At home, farm, str (<i>Specify)</i>		703 2 1110	28f. Location (S City or Tow	Street and Number vn, State)	or Rural Route Number,
To the Hospital or within 24 hours af To the Funeral D' completely filled in	Medical	(Check only 2 Medical Examone)	nysician: To the best o miner: On the basis of and manner stat	examination and/or in	vestigation, in my o	opinion, death occu	rred at the time,	date and place, an	d due to the cause(s)
To To to con	Z	29b. Signature and title of certifier	el Staff	physicia	29c. Licens	e number		29d. Date signed (Month, Day, Year)
2		1 . 1. 11.	VATELLIJI. JY	1BVMC	4940 12	Argen	Ale	BALTIMO	m md21224
Sta Regist		31. Date filed (Month, Day, Year)	09 Registra	r's Signature	Cartana de				

		•	For State Registrar	partment of Health and Certificate of Death		eg. No. 200	9 00120
	Dhyaiais		1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	th Day Ye	3. Time of Death
	Physicia /Medic		Doris Rae Weber		January	04, 2009	9 6:50 P. M
	Examin	er	4a. Facility Name (If not institution, give street and number) 1431 Burton Ave.	4b. City, Town, or Location of Death			re County
	Funeral Director		5. Social Security Number 6. Sex 1 → 7. Age (In yrs. last birtho	Months Davs Hours Min.	8. Date of Birth Month, Day July 24	9. 1926 Li	Birthplace (State or Foreign Country) UCDETVILLE, MD.
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	r Location			10d. Inside City Limits
	Maryl	ţō	Maryland Baltimore County Luther	rville			1 □Yes 2 HNo
	h the)irec	10e. Street and Number	10f. Zip Code	1	l0g. Citizen of What	t Country?
	ath wil	ral	1431 Burton Ave.	21093		United St	
0000	Irs a	by Funeral Director	11. Marital Status 1 □ Never Married 2 ♣ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ♣ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 No Specify:	pecify Yes or No- to Rican, etc.)		American Indian, White, etc. White
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٧	vithin ane. Ihan "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of wor te. DO NOT use retired) HOME Maker	9	Own Ho	Olife
7	filed w Hygie ther t		17. Father's Name (First, Middle, Last)		ne (First, Middle,		JIIC
2	Aental Aental rked c	To Be	Raymond Frank Gill	Esther	Rae Carv	er	
Mary	alth and I		19a. Informant's Name/Relationship (Type. Print) (Husband 19b. Mr. Daniel Raymond Weber, Sr. 14:			r, City or Town, Sta .e, Maryla	
ב ב	jes 1 a t of He If Item or oth		20a. Method of Disposition 20b. Place of D cemetery, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of D cemetery, Dullanova	sposition (Name of crematory or other place) Jan.	Date 10,	20c. Location - City	
Daillio	it. Pag rtmen rtant: njury e		4 □ Donation 5 □ Other (Specify)			Timonium,	
מ	permii Depar Impor any ir once.		21. Signature of Funeral Service Licensee - Java 2	22. Name and Address of Facility Peaceful Alternati 2325 York Road	ves Fune Timonium	ral&Crema , Marylar	ation Ctr.,P.A. nd 21093
			23a. Part / Enfer the discrise, or complications that caused the death. Do not shork, of heart failure. List only one cause on each line. Immediate Cause (Final			rest,	Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	DIAL INFARCTIO	·~		-
1	Examiner		ATRIA	L FIBRILLATIO			
	p ti	iner	Sequentially list conditions, if ally, feading to immediate cause. Enter Underlying				
	and and til-trans	Examiner	The transfer of the transfer o	ESTIVE HEART	FAILU	ie	
0100,	ficate be executed physician and s the burial-transit	dical	d.				
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O. DOX	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending to the funeral Director. After this completely filled in by the funeral director, page 2 should be detached for use as	ysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of Month	f delivery Day Year
Ę.	s that ined b	by Phy	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did to	bacco use contribut	te to the cause of death?
cords,	w require s been sig should b		DEMENTIA		1 🗆 Y	es 2□No 3□	Probably 4 Unknown
ו חפני	The law racate has be page 2 sho	Completed			24a. Was a autops perfor	sy prior med? deat	e autopsy findings available to completion of cause of h? Yes 2 □ No
V [2	siclan certifi rector,	Be	25. Was case referred to medical examiner? Hospital: Ho	I Others	ath (Check only or	,	
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm building, etc. (Specify)	street, factory, office	28f. Location (S City or Town	treet and Number o n, State)	r Rural Route Number,
	le Hospit	ledical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, concluded the physician of the basis of examination and/or and manner stated.	or investigation, in my opinion, death occi-	urred at the time, of	late and place, and	er as stated. due to the cause(s)
<u> </u>	To the Committee of the committee of the	ž	29b. Signature and title of certifier	29c. License number	2	29d. Date signed (M	onth, Day, Year)
	6		30. Name and address of person who completed cause of death (Item 23a) (Ty	Pe, Print) RD6(BPONK R	1 510	312 5	PAWS MAZUSZ
Ï	Sta Registra		31. Date filed (Month, Day, Year) JAN 0 6 2009 32 Registrar's Signature	29c. License number DSOL3 pe, Print) RDG(BROOK R		,, ,	ļ

DHMH 17 Rev 1/2001

Please Type or Print in Black Indeline. Ensure All Copies Are Legible. Amend #27 Pestate of Waryland / Department of Health and Mental Hygiene 1 = For Stata Ragistrar Per FH G887 Celfficate of Death amend #20a-c Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** - A-M /Medical 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner emoria 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5.248-2849688 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Days Year 1 □ M 2 💢 F Months Hours Min 257204 84 Yrs. Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after thygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced Specify 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Th Department of Health and Mental Hygie Importent: If item 27 is marked other tany Injury or other traumatic event, III ODGs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be ပ Vel 19a. Informant's Name/Relationship (Typ), Print) 19b. Mailing Addrass (Street and Number or Ru al Route Number, City or Town, State, Zip Code) 20c. Location - City r Town, State 20b. Place of Disposition (Name of commetery, crematory or other place)
MT. Carmel Cemetery 20a. Method of Disposition Date 1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 1/12/2009 Baltimore, MD 22. Name and Address of Facility Phillip A. Weatherford 21. Signature of Funeral Service Licensee All 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): HEANT /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ten Due to (or as a consequence Examiner Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ğ Month Dav Year 4□Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ficate has been sig r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 1 Yes neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 ☐ Yes 2 No Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Attending PNJ licia) of person who completed cause of death (flem 23a) (Type, Print) 30. Name and address

Registrar

State

31. Date filed (Month, Day Year)

Balt none

- Universite

32. Registrar's Signature

		1 - For State Registrar	State of	of Marylan	id / Depa <i>Cei</i>	artment of H rtificate of L	lealth and Death	Mental Hyg	giene 0	09	00122
		1. Decedent's Name (First, Middle	Last)					2. Date of Dea Month	ath Day	Year	3. Time of Death
Physic /Med		Maynard		F.	Walsh			January		009	5:30 a M
Exami		4a. Facility Name (If not institution,	give street and nu	ımbər)		4b. City, Town, or	Location of Dea	ath	4c. County	of Death	
		Longview Nurs	ing Home				nester			rroll	
Funera		,	6. Sex 1⊠M 2□F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hi Hours Mi	n. (Month, Day	h v, Year)	9. Birthp	olace (State or Foreign
Director		214-16-9607	1571M 5 1	83	Yrs.			Jan 5,	1925		land
pu *		Usual Residence of Decedent 10a. State 10b. County		10c, Cit	y, Town or Lo	cation				1	10d. Inside City Limits
Aarylt sho	5	MD Balt	imore			Reisters	rtoun				1 ☐ Yes 21 No
the N	ect	10e. Street and Number	IMOLE			10f. Zip Code	COWII		10g. Citizen of V	What Cour	ntrv?
with Sa or	0	607 Shirle	v Manor I	Road		211	L36		-	S.A.	
Jeath ms 23	era	11. Marital Status	12. Was Dec	edent Ever in U.	.S. 13. \			(Specify Yes or No- orto Rican, etc.)		e - Americ	can Indian,
or Iter	Funeral Director	1 Never Married 2 Marrie	Armed F	2 No				erto Rican, etc.)		ck, White,	etc.
al', c	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, G Year or I	nve Dates: WW:		1 ☐ Yes 21KD No	Specify:		Specify	"i	White
72 hr	Completed	15. Decedent' (Specify onfy highes	s Education)	(Give	tent's Usual Occupa	during most of w	orking	16b. Kind of Bu	usiness/Ind	dustry
Athin han "	İd	Elementary/Secondary (0-12)	T	(1-4or 5+)	life. I	DO NOT use retired					
led w tygien ther ti		47 Enthada Nama (Cint Atiddle)	agtl	2		Claims I		ame (First, Middle,	Social		urity
Idally STATION AT LATE 13-0050 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene, see marked other than "natural", or Items 23a or 28a-f show aumatic svent, the Medical Examinar must be notified at	Be	17. Father's Name (First, Middle, L	walsh Walsh				Vic			θ)	
T y Ic	၉	Edward 19a. Informant's Name/Relationsh		.1	10b Mailie	a Address (Street		Rural Route Numbe		State Zir	Codel
d 2 st d 2 st th an 7 ls r traur		Michael P. Wal	, , , , , ,	on		•		Finksburg		21048	
If 5, INIAI YIAIIU ZIZIOUOOO S 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic svent, the Mcdical Examiner must be notified at		20a. Method of Disposition	511 50			sition (Name of matory or other place		Date	20c. Location -		
ages ont of t: If it		1 Burial 2 □ Cremation 1 □ Donation 5 □ Other (Sp		State			1	7/09	Doleins		Marriand
parmit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service L		Ga		of Faith Name and Addres		11824 Res			Maryland
Dermij Permij Depar Impor		1 Suffy	BE	-	F	LINE FUNI	ERAT. HOM		erstown,		21136
		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that	caused the deat						, 1110	Approximate
Pnysician		Immediate Cause (Final	only one cause on	Ala la	" me	orls D	10mr	instic			Interval Between Onset and Death
/Medical		disease or condition resulting in death)	a. Due to	(or as a conseq		26 3 1	2 (11)6	7116		-	
Examiner	1			,							
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a conseq	uence of):						
cutec nd ransi	ami	Cause (Disease or injury that initiated events	c								
e exe	Ē	resulting in death) Last	Due to	(or as a conseq	uence of):						
icate be executed physician and the burial-transit	dicai Examiner		d							-	
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ath cer titendir for use	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live	itcome of pregna birth 2 ☐ Feta	Ideath 3	Ectopic pregnancy			23d. Dat Moi	te of delive nth	ery Day Year
the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟ Preg 9□ Unkr	nant at time of d	eath 5L	Other (specify)					
hat the sed by detac	by Physician/Me	Part II. Other significant condition	ns contributing to a	death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use conti	ribute to th	he cause of death?
law requires that some as been signed 2 should be a		chronic A		HORKH				1 🗆 Y	es 2□No	3 🗆 Prob	pabiy 4 XUnknown
v requ	Completed							24a. Was a	an 24h V	Were auto	ensy findings available
ne lay	E							autop:	med?	death?	ppsy findings available mpletion of cause of
clan: The continuation of the continuate of the		25. Was case referred to medical					20 Di(D			1 ☐ Yes	2 No
s cert	o Be	examiner?	Hospital:	Inpatient 2	ER/Outpatien	nt 3 DOA Othe		eath (Check only or Home 5 Aesid		er (Specif	<u></u>
a Phy er this	-	27. Manner of Death	28a. Date	of Injury	28b. Time of				ow injury occurr		77
Attending at death. ector: After by the fune	atio	1/2Natural 5 ☐ Pending 2 ☐ Accident investig		nth, Day Year)	Injury		Yes 2 □No				
Atte	Hic	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 288. Plac	e of Injury - At ho		eet, factory, office		28f. Location (S City or Tow		er or Rura	al Route Number,
talor safte	Certification;		34						.,,		
To the Hospital or Attending Physician: The law requires that the death certificate the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director. Age 2 should be detached for use as	edicai	(Check only 2 Medicel E	xeminer: On the l	pasis of examina	wiedge, death	n occurred at the tim vestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the c curred at the time, o	ause(s) and ma date and place, a	nner as st and due to	tated. the cause(s)
thin 2 the the mplet	Med	one) 29b. Signature and title of certifier	and mar	ner stated.		29c. License	number	2	29d. Date signed	d (Month,	Day, Year)
F3F8		> apuns	white	MD		DF	170	5			
IX		30. Name and address of person			n 23a) (Tvpe.	Print)		1 . 1 . 2	0.	pro	
W.		M. PANSURIV	A 34	9 mal	mlw	DR,	nest	minster	WD	21	(5/
S Regis	tate trar	31. Date filed (Month, Day, Year)	A.	Registrar's Signa	bar	lad.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-00031 State of Maryland / Department of Health and Mental Hygiene 2009 00123 Mario Williams Certificate of Death 1- For State 2. Date of Death Registrar Decedent's Name (First, Middle,Last) Month Day January 1, 2009 2015 hrs Physician/ 11i aum s Medical Examiner ario 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) NIA **Baltimore** Johns Hopkins Hospital 9. Birthplace (State or 8. Date of Birth (MM/DD/YYYY If Linder, 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex Social Security Number **Funeral** Days Hours Min Months Country) Director 12-92-9595 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a, State 1 Yes 2 No s 23a or 28a-f show e notified at once. 10g. Citizen of What Country with the Maryland Funeral Director 10e. Street and Number 21216 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married Married Yes No specify: Specify: 9 Yes 2 If Yes. Give Year Divorced Widowed Kind of Business/Industry à 16a. Decedent's Usual Occupation (Give kind of work done Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within 72 l Department of Heafth and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Williams If item 27 is marked Be or other traumatic event, (Street and Number or Rural Route Number, City or Town, Slate, Zip Code) 19b. Mailing Address 19a. Informant's Name/Relationship (Type, Print) Wood Gate Woodlawn Gwendolyn MOH 20b. Place of Disposition (Name of cemetery Date 20a. Method of Disposition crematory or other place) Baltimore, Removal from State 2009 Cremation 3 Baltinuce, MI Burial Memoria Important: Other Specify Vallahr 22. Name and Address of Facility Signature of Funeral Service Licensee MD Z1133 Approximate Interval r complications that caused the death. Do not enter the mode of dying, such as dardiac or respiratory arrest, shock, or heart Between Onset and er the disease. **Physician** Death ist only one cause on each line 1edical Gunshot wound of head Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and trans. Physician/Medical AMENDED UNPENDED attending physician or use as the burial -23d. Date of delivery 23c. If yes, outcome of pregnancy Box 68760. Day Year 3 Ectopic pregnancy Month 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions No 3 Probably 4 V Unknown Records, P.O. ð 24b. Were autopsy findings available 24a. Was an Completed prior to completion of cause of s been s autopsy death? performed? 1 V Yes No certificate has ✓ Yes 2 director, page 2 26. Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: **Division of Vital** Be Other₄ Residence 6 Hospital: 1 / Inpatient DOA examiner? ER/Outpatient 3 1 Yes this ٥ 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year Jan 1, 2009 After 27. Manner of Death Subject shot Medical Certification: 0055 hrs 1 ✔ Yes 2 Natural Pending Investigation within 24 hours after death.

To the Funeral Director: filled in by the 28f. Location (Street and Number or Rural Route Number, City Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 700 block Luzerne Avenue, Baltimore, Md Could not be 3

State

4 V Homicide

29b. Signature and title of certifie

Name and address of persor

Theodore M. King, Jr., MD

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

OCME

29d. Date signed (Month, Day, Year)

January 2, 2009

(Specify) Bar/tavern

who completed cause of death (Item 23a)

Ensua

Assistant Medical Examiner

Registrar's Signati

and manner stated

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month WILLIAMS January LEON **JAMES** 03 0127 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death UNION MEMORIAL HOSPITAL BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) Date of Birth (Month, Day, Year) Months Days Hours Min. 1 X M 2 T F 216-42-5390 63 DEC. 11 1945 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No MARYLAND BALTIMORE WHITE MARSH 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 348 LORELEY RD U.S.A. 21162 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2€€No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 200 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 🕱 No Specify. Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CAB DRIVER 12th grade SELF 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BERNARD WILLIAMS GLADYS WILLIAMS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah M. Williams/Daughter 4523 Furley Ave., Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State METRO CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 01-10-09 BALTIMORE, MARYLAND 21. Signature of une al Source Licensee 22. Name and Address of Facility WM C BROWN COMMUNITY FUNERAL HOME -HARFORD, P.A. S PHILADELPHIA BLVD., ABERDEEN, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): disease or condition resulting in death) ildichown Full one of the total to (or as a consequence of). 8 Tricuspia Due to (or as a consequence of): If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? kidney 3 Probably 4 ☐ Unknown manic 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) Hospital: 2 NO Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

Examiner Box 68760, P.O. Records, Division of Vital

be executed burial-transi attending physician for use as the buria has I page 2 certificate | After this funeral spital or Attending P nours after death. neral Director: After t filled in by the funera ours

Physician

/Medical

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event."

To the Ho within 24 h To the Fui completely	Modio
4	
Sta Registr	

Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that in it littled events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed 25. Was case referred to medical Be 1 ☐ Yes Certification: To 27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifies (Check only one) 29b. Signature and hitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AT 243 8946 Januar 03 2009

DHMH 17 Rev 1/2001

BURGOYNE

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31. Date filed (Month, Day, Year)

GREGORY

32. Registrar's Signature

BALTIMORE

21218

MD

State of Maryland / Department of Health and Mental Hygiene 2009 00126 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 2, 2009 6:30A M JEAN CATHERINE WATSON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) Examiner Baltimore 201 Abbey Hill Court Timonium If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 M 2 XX Months Yrs. February 27, 1927 Maryland 579-28-3365 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evard in coust to a south deat 1 ☐ Yes 2 ☐ No Director Timonium Maryland Baltimore 10f. Zip Code 10g, Citizen of What Country 10e. Street and Number death with 21093 USA 201 Abbey Hill Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or Iter 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify White Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **Owner** Catering 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie Catherine Ouandt Christopher Rudolph Lindeman Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trauonce. 201 Abbey Hill Court Timonium, Maryland 21093 David Richard Watson Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 🕮 remation 3 ☐ Removal from State GreenMount Crematory Jan 5.2009 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell -Wiedefeld Funeral Home Inc nature of Funeral S 6500 York Road Baltimore, Maryland 21212 nnis e for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, shock, or heart failure. L acciden Immediate Cause (Final erebrovascular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a gansermence of: Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ੬ Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 5 ☐ Pending investigation 1 X Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b, Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) endall Krav lowsanten

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

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			_ 101	artment of Health and Menta rtificate of Death	Reg. No. 200	9 00127
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	Physicia		Mary Jane Zerry		uary 3, 2009	1:25 A M
in.	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dea	
1			Montgomery Hospice Casey House	Rockville	Montgom	ery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		e of Birth 9. Bi	rthplace (State or Foreign
М	Director		513-32-3338 86	Nov	. 12, 1922 Mis	ssouri
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	ns 2; mus	Funeral		Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican,		
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21215-0036	72 hours after death with the Maryland 'natural", or items 23a or 28a-f show ideal Examiner must be notified at	l by	3 🕅 Widowed 4 □ Divorced If Yes, Give Year or Dates: WWII	1 ☐ Yes 2 🕅 No Specify:	Specify:	White
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121	ithin ne. han "	ld m	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		
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Z	hould nd Me mark matic	ဥ		ng Address (Street and Number or Rural Route		Zin Code)
Ma	nd 2 s Ilth ar 27 is 27 is			Chiswick Court #2C,		
<u>6</u>	ges 1 and 2 should be filed within 72 hours after death with the Maryla at of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Marical Examiner must be notified at or other traumatic event, the Marical Examiner must be notified at			osition (Name of Date _	20c. Location - City o	
E O	Page: lent o nt; If		1 Magurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Mary 18		, Rockville	e, Maryland
Baltimore,	mit. I sartm sortai r inju			2. Name and Address of Facility Robert A. Pumphrey Funeral		
Ö	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once.		Willian a. Kingley M01173	800 W. Montgomery Avenue,	Rockville, Maryla	and 20850
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respin	ratory arrest,	Approximate Interval Between
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Β.	deat	sicia		☐ Ectopic pregnancy ☐ Other (s <i>pecify)</i>	Month	Day Year
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Ś	es thi igned be de		Part II. Other significant conditions contributing to death but not resulting in the Hypertension	Inderlying cause given in Part I. 23	e. Did tobacco use contribute	
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Division of Vital Records,	law l has b	Completed by	Chronic Obstructive Pulmonary Di	sease 24	autopsy prior to	utopsy findings available completion of cause of
H F	Physician: The la rthis certificate has ral director, page 2	So		1[performed? death? □Yes 2 🔯 No 1 □ Ye	s 2□No
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isi	Attenderation of the	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s		cation (Street and Number or I	Rural Route Number,
Ö	after Dire	Certification: To	4 ☐ Homicide determined building, etc. (Specify)	Cit	y or Town, State)	
	spita hours inera ly fille		29a. Certifier 1 X Certifying Physician: To the best of my knowledge, dea			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurred at tr	ne time, date and place, and di	e to the cause(s)
_	Parity of Arity	Σ	29b. Signature and title of certifier Docelyne Kouerkhou, mi	29c. License number 20063748	29d. Date signed (Mor	
	061				January 3	5, 2009
	7		30. Name and address of person who completed cause of death (Item 23a) (Type Jocelyne Kouatchou, M.D. 6001 Munc		willo MD 200	55
	Sta	te.		aster Mill Road, Rock	ville, MD 208	J.J.
		ar	JAN 0 6 2009 32. Registrar's Signature	ares		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** C. Zapf Mary 2009 ar January 3:10 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Center Timonium Baltimore Co. 8. Date of Birth Month, Day, Year, Pob. 25,1917 . Age (In yrs. last birthday) 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number **Funeral** 212-52-8200 Hours 1 □ M 2 🛣 F Months Days Min. Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location show 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov any injury or other traumatic event, the "Motical Examination in Baltimore City N/A 14 Yes 2 □ No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1623 Darley Ave. 21213 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: ð Specify: 3 Midowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be Margaret E. Ervin John J. Schwartz ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21222 2728 Plainfield Road Dundalk, Maryland Joseph F. Zapf (Grandson) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 Burial 2 Cremation 3 Removal from State 1/5/2009 Gardens of Faith Cem. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) death certificate be executed sician and burial-trans resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 X No Month Year Day 5 Other (specify) 9 Unknown ed by t detach s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy rmed? 2 **X** No 1 □ Yes 2 🗆 No 25. Was case referred to medical director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 1 ☐ Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

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Maryland 21215-0036

Baltimore, IANUARY

> The law requires or Attending Physician: Division of within 24 hours after death
>
> To the Funeral Director; and completely filled in by the f To the Hospital

State Registrar

29a, Certifier

(Check only one)

29b. Signature and title of certifier

29c. License number

🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and and ss of person who completed cause of death (Item 23a) (Type, Print)

JACKIE JONES. CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 0 5 2009

09-00040	
Timothy Brigham	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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Wedical Examine		Timothy J. Brigh 4a. Facility Name (if not institution, given		41	. City, Town, or	Location of I			ity of Death	
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the I	Medical	one) 2 Medical Examine	er:On the basis of examination and manner stated.	and/or investigat			urred at the time, da			
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	-	30. Name and address of person who	completed cause of death (Ite	m 23a)					, =====	
			Assistant Medical Exam		enn Street, I	Baltimore,	MD 21201			
Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signa	harts	,					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 Georgia Ann Bradshaw January 8:20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3816 27th & D Street/P.O Box Chesapeake Beach
If Under 1 Year | If Under 24 Hrs. Calvert Birthplace (State or Foreign Country)
 Oh10 5. Social Security Number 8. Date of Birth (Month, Day, Year) 07/18/1942 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2√2 F 276-36-1965 66 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ir than "natural", or Items 23a or 28a-f sho MD Calvert Chesapeake Beach 1 ☐Yes 24 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3816 27th & D Street/P.O. Box 311 20732 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No IfYes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: White ≥ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglen Important: If item 27 is marked other the any hiury or other traumatic event, the once. Homemaker N.A. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Livingston Marrs Nina Morris Sproles ို 19a. Informant's Name/Relationship (Type. Print) Dickie Bradshaw/Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3816 27th & D Street/P.O. Box 311 Chesapeake Beach, MD 20732 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 101/07/2009 Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service License 7522 Connelley Dr., Ste. P., Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Q CInoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria 8 3 1 AW (4/04) Records, P.O. Box 68760 Hospital or Attending Physician; The law requires that the death certificate be Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the a I be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate Vital 2 No 1 ☐ Yes 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this ō 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 Pending n 24 hours after death.

ie Funeral Director: A
bletely filled in by the ft 1 ☐Yes 2 ☐No 2 Accident investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number whan 30. Name and address person who completed cause of death (Item 23a) (Type, Print) Owensville Road, West River 134 32 degistrar's Signature State

Registrar

Liner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death **Month Physician** 0:00A M 2009 /Medical a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Birthplace (State or Foreign Country) Date of Birth Month, Day, 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show 1 Yes 2 No **Funeral Director** timore 10g. Citizen of What Country? 10e. Street and Number . Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. per nit. Pages 1 and 2 should be filed within 72 hours after Derartment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite am injury or other traumatic event, the Widcal Event is once. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Name (First, Middle, Last, Maryland Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee Balto 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) DEMENTIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jissase or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2X No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1∐Yes 2X No ၉ 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA HOSPICE 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 One X Nurse Practition earner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name any address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar JACKIE JONES,

31. Date filed (Month, Day, Year)

CRNP

Barko

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

State of Maryland / Department of Health and Mental Hygien ? Certificate of Death

3 Time of Death

2:28 AM

2889

MARYLAND 21204

TOWSON.

Reg. No.

Physician
/Medical
Examiner

For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY Rosanna Rush Barger 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs.

Funeral Director

Maryland the

death with permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event. The Mental Once.

Physician /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Division of Vital Records, P.O. Box 68760 physician the attending p for use as t cate has been signed by the page 2 should be detached certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Andrew Rush Rosanna McKinstry 19a. Informant's Name/Relationship (Type. Print) George F. Barger, Jr. (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee É X ausakn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CONGESTIVE HEART DISEASE disease or condition resulting in death) Due to (or as a consequence of): ISCHEMIC CARDIOMYOPATHY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ACUTE RENAL FAILURE Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ■ No 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 🗌 Yes 24a. Was an autopsy performed? 1 ☐ Yes 21 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 XNo 1 X npatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier 29b. Signature and title of Certifier 29c. License number D 25886 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4c. County of Death Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 □ M 2 🖾 F 12/03/1922 Ireland 216-16-8307 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County d other than "natural", or items 23a or 28a-f show event, the Medienl Evaniner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number U.S.A. 21234 2600 Wendover Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11, Marital Status Black, White, etc. 1 □Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Police Department School Guard -Baltimore Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2122 Bellvale Road - Fallston, Maryland 21047 20c. Location - City or Town, State Metro Crematory, Inc. 01/08/2009 Baltimore, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 Approximate Interval Between Onset and Death YEARS YEARS Examine DAYS Physician/Medical 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 DNo Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the within 2 29d. Date signed (Month, Day, Year) 2000

State Registrar CEBAL

31. Date filed (Month, Day, Year)

D.

32. Registrar's Signature

7601 OSLER DRIVE.

			For State	State o	f Marylan		artment of rtificate of		and Mental	, 0	0000	00122	
	Physicia	an	1. Decedent's Name (First, Middle			00	illioate of	Dealir	2. Date Mont	Reg. of Death h	Day Year	3. Time of Death	
	/Medic Examin	cal	Ann Marie Bro	, give street and nu	mber)		4b. City, Town,		of Death	lary :	2 , 2009 4c. County of Death		
	Funeral Director		6539 Tydings 5. Social Security Number 217–24–1999	Road 6. Sex 1 □ M 2 🔀 F	7. Age (In yrs. 79	last birthday) Yrs.	E1de If Under 1 Year Months Days		24 Hrs. 8. Date	th, Day, Ye	Carrol 9. Birth Cou 929 Mary	place (State or Foreign ntry)	
Schould be filed within 72 hours after death with the Marviand	ref show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Balti	more	10c. Cit	y, Town or Lo			1000		2	10d. Inside City Limits 1 ☐ Yes 2 ☒ No	
	3a or 28a	Il Director	10e. Street and Number 6824 Richardso		_Da	TTIMOI	10f. Zip Code	207		10g.	Citizen of What Coul	ntry?	
000	is a range should be lied within 12 hours after beath with the wallyfall of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is Medical Even in a market by notified at	by Funeral	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Dec Armed Fo	2[X No ve			Hispanic Ori oan, Mexican	gin? (Specify Yes , Puerto Rican, et	or No-	14. Race - Ameri Black, White,		
2 1 2 1 3 1 2 1 3 1 3 1 3 1 3 1 3 1 3 1	giene. er than "natur,	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12)	pation during most ed)	t of working	sing							
מוש אינו	Mental Hy rked othe	To Be (17. Father's Name (First, Middle, Sebastian Gian	*					r's Name <i>(First, M</i> ephine Gi		den Surname)		
, wan	Health and tem 27 Is me tem 27 Is me other traums		19a. Informant's Name/Relations Jo Anne Dickins		iter						ty or Town, State, Zi _l Maryland 2		
	Department of Health Important; if item 271 any Injury or other tra		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State	emetery, crei	esition (Name of matory or other pla edral Cet		Date 1/6/200		Location - City or To altimore,	,	
	Department of Department of Important: If i any Injury or once.		21. Signature of Funeral Service	icensee	pho		Name and Addr uneral H 630 Edmo	ess of Facilit Ome of ndson	Sterling Catons Avenue;	Asht ille, Cator	on Schwab Inc. nsville, M	Witzke D 21228	
	hysician /Medical		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on e	each line.	lzheim	er the mode of dy		cardiac or respirat	ory arrest,		Approximate Interval Between Onset and Death Years	
	and -transit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	с	(or as a conseq								
A COLOG.	ding physician and as the burial-transit	dical	IF FEMALE:	d									
the death	ned by the attending properties as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							_	23d. Date of deliv Month	Pery Day Year	
ocuires the	should be de	ρ									cco use contribute to the cause of death? 2 XNo 3 Probably 4 □ Unknown		
O the Hoenital or Attending Physician. The law requires that the death certifi	certificate has be ector, page 2 sh	Completed	OF Mice and a state of the stat						1 🗆 '	Was an autopsy performed ∕es 2⊠	? death?	opsy findings available impletion of cause of	
	fter this certific	on: To Be	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence							th <i>(Check only one)</i> Daughter 's Daughter 's Daughter 's Daughter 's Daughter 's Daughter 's Daughter 's Daughter 's			
	within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:								ion (Street or Town, St	eet and Number or Rural Route Number, State)		
d Hoenits	e Funeral	Medical C	29a. Certifier (Check only one) Certifyin 2 Medical	Examiner: On the b	e best of my kno basis of examina aner stated.	wledge, deat tion and/or in	h occurred at the vestigation, in my	time, date an opinion, dea	nd place, and due the the	o the caus time, date	e(s) and manner as a and place, and due t	stated. o the cause(s)	
r d	withir To th comp	Me	29b. Signature and title of certifier	hller M	D			se number	8 3		Date signed (Month,	Day, Year)	
_	Le_		30. Name and address of person	who completed cau	se of death (Item	n 23a) (Type, Swite	Print)	10tes2.	m MD	2113	36		
	Sta Registr		31. Date filed (Month, Day, Year)	32.	Registrar's Signa	ture							

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Miller . Day Year **Physician** Josephine Camp \mathbf{P}^M 2009 JAN 12:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 406 Hamilton Ave. Silver Spring Montgomery Date of Birth (Month, Day, Year) 01/17/1912 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Min. 1 □ M 2 🖼 F Months Days Hours 96 Yrs Director 227-01-0469 VA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. It was 23a or 23a Director 1 ☐ Yes 2 XNo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 406 Hamilton Ave. 20901 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 TNo <u>≥</u> Specify. Specify: 3

Widowed 4 □ Divorced Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ellis Miller Elizabeth Thompson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas G. Camp, Jr./Son 406 hamilton ave. Silver Spring, MD 20901other 1 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Pages 1 Jan permit. Page: Department o Important: If any Injury or <u></u> = 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory Inc.2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Services MO1533 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cerebrovasu disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or deriving Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed and burlal-trar Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No for Month Day Year 5 Other (specify) the 9 🗆 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? Jas autopsy The performed' certificate ! 2. No 2 🗆 No 1 □ Yes Physician; 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending 1 🗷 Natural within 24 hours after death.

To the Funeral Director: # 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only onel 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

9 acker

Rockledge Dr., Bethesda, MD 20817

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

-ndrisano

32.

Registrar's Signature

Jeffery

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 20a-c per fh 8887 1-7-09 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Edward Joseph Courtney Jr. 01-02-2009 1810 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern MD Hospital Clinton If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 04-19-1928 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 XM 2 ☐ F 80 Yrs. 579-38-2787 Virginia **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f sho The Medical Examiner must be notified at 1X Yes 2 No MD PG Ft. Washington Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9704 Overview Ct. 20744 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes M☐ No Specify: Specify: Black þ 3 ☐ Widowed 4 🎇 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ft. Belvoir Civil Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph E. Courtney Sr. Ella Louise Murray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any Injury or other trau Carl Courtney/ Son 9704 Overview Ct. Ft. Washington, MD 20744 20c. Location - City or Town, St Cheltenham, Md. Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Veteran CEM. 01 09-2009 ALEXANDRIA,

22. Name and Address of Facility Ronald Taylor II FH 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puneral Service Licensee 10583 Middleport Ln. White Plains, MD tronos 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Ence Exami HYPOXIC sician and burial-trans Due to or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 ☑No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

sate has been signed by the page 2 should be detached Division of Vital Records, To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or

28a-f show

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

within 72

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2 State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

BO. Name and address of persum who completed cause of death (Item 23a) (Type, Print)

Make Kaniam, Farzad 7503 Surratts Rd. Clinton, Hd. 20135 32. Registrar's Signature

and manner stated

JAN 0 7 2009

29c. License number

29d. Date signed (Month, Day, Year)

1/03/09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#30perDVR,G88/,I///09,w5
State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical Town, or Location of Death Examiner If Under 24 Hrs Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Director IYANIA 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the "waldral Examinating to a the mottling at 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married 21215-0036 1 ☐Yes 2 No Specify \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) land 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname Maryl 19b. Mailing Address (Street and Number or 607B Demby Baltimore, Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremanon 5 Other (Specify) 3 Removal from State TIMONIUM MD 21. Signature of Funeral Service Licens Funeral Horse BAKKMOVE, ND 21215 a 23a. Part 1. Enter the diserve, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Houte **Physician** intracerebral disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a sunsequence of): sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Day Year 5 ☐ Other (specify) ed by the a Ö 9 Unknown 9 Unknown ٦ signed I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? certificate Vital 2 NO 1 ☐ Yes 2 UNG 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 24 hours after deat e Funeral Director; by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the the within 2 29b. Signature and the of oer lifter 29c. License number 29d. Date signed (Month, Day, Year) ٥ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel Air, MD. 21014 Upper Chesapeake Health Ctr. Kharal Z. 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Alverta Charlotte Duke 2:52 Рм 01 03 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Hospice 7. Age (In yrs. last birthday, 85 Yrs. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F Maryland Director 02/21/1923 218-18-9495 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Baltimore 1 XYes 2 No MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21204 555 W. Twosontown Blvd Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed withit Health and Mental Hygiene. Book Keeper Retail 7 is marked other traumatic event, I 17. Father's Name (First, Middle, Last) land 18. Mother's Name (First, Middle, Maiden Surname) Be Mary UNK James L. Young 2 Marv 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai once. 866 Cornelia Ave. Palm Bay, FL 32909 Gregory Krolczyk/Son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/07/2009 Anatomy Gifts Registry Hanover, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 7522 Connelley Dr., Ste. P, hanover, MD 21076 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** realco /Medical Due to (or as a consequence of): **Examiner** TICEMIA weeles Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue to (or as a consequence of): Examiner sician and burial-tran Due to (or as a consequence of) Physician/Medical attending physical for use as the b 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 s has autop performe 2 certificate 1 ☐ Yes 2 ☐ No 1 □ Yes Vital funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of this Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Attending 5 Pending investigation n 24 hours arter the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ŏ Hospital 17 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

We dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical sompletely (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

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555 W.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)~

nes MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2009 8:45 P M Hector Paul DiNardo, Jr. January 4, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2215 Dalewood Road Timonium Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, October 9, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year Months 1 XM 2 □ F 215-22-4456 81 Maryland Director Usual Residence of Decedent Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show ir than "natural", or Items 23a or 28a-f sho 1 ☐ Yes 2√☐ No Director Baltimore Timonium Maryland Pages 1 and 2 should be filed within 72 hours after death with the ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2215 Dalewood Road 21093 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛛 No Specify: Specify: \$ ww II uhite 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Dentist Medical 7 is marked other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hector Paul DiNardo, Sr. Louise Verderame ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Margaret F. DiNardo (Spouse) 2215 Dalewood Road Timonium, Maryland 21093 permit. Pages 1 and:
Department of Health
Important: If item 27
any injury or other tr
once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Buria! 2 ☐ Cremation 3 Removal from State Joseph Church Cemetery 1/10/2009 5 Dether (Specify) Cockeysville Maryland 4 Donation 22. Name and Address of Facility 21. Signature of 21204 Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ancrean **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
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1 □ Yes 2 □ No 24a. Was an autopsy performe 1 □Yes 2 ☑No 25. Was case referred to medical examiner? Be director, 26. Place of Death (Check only one) Other: 4 Nursing Home Samesidence 6 Other (Specify) 1∐Yes 2 Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After → Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: , d in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral DI

completely filled in 29a. Certifier **Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific

Registrar

State

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

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certificate no.: 2009-00139

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/Medi	ca
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Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Hydical Exeminer must be routified at once.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Sta

•	State Registrar	State Registrar Certificate of Death Reg. No. 2009 0014									140					
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er	4a. Facility Name (If not institution, give street and number)							4b. City, Town, or Location of Death					4c. County of Death			
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	5. Social Security N	6. Sex 1 □ M 2		7. Age (In yrs. last birthday)			Months Days Hours Min. (Month,			8. Date of Bi (Month, D	, Day, Year) Co			thplace (State or Foreign ountry)		
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			State Registrar 1. Decedent's Name (First, Middle, Last)	-	Certificate of		Reg. N	.2009	3. Time of Death
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	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birti	Months Davs	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Year	9. Birti	nplace (State or Foreign
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(0	be filed within 72 hours after death with the Maryland that Hyglene. ad other than "natural", or items 23a or 28a-f show event, I'm invidice Expr. in minut in unified at	Funeral	11. Marital Status 1 ☐ Never Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ■ No	If Yes, specify Cub	Hispanic Orlgin? (Specify an, Mexican, Puerto Rica	Yes or No- an, etc.)	14. Race - Amer Black, White	
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re, P	s 1 and 2 should of Health and Men item 27 is marke other traumatic.		20a. Method of Disposition	20b. Place of	Disposition (Name of	Hameda		Location - City or 1	
ltimore,	0 ~ = =		1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	y, crematory or other pla L & U	2m 1-10-	2009 La	nsdow	ie, mD.
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral/Service Licen	1	22. Name and Addre	ess of Facility 3405	w.E	20 th	in St.
	_		23a. Park Enter the disease, or complic shock, or hear, failure. List only one	cations that caused the death. Do no	ot enter the mode of dyi	ng, such as cardiac or re	spiratory arrest,	- Becar	Approximate Interval Between
da.	Physician		Immediate Cause (Mnal disease or condition	Sepsis					Onset and Death 3 days
and the second	/Medical Examiner		resulting in death)	Due to (r as a consequence o	of):				
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	n and al-trans	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence o	of):				
8760	or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	dical	U d.						
Box 6	eath certifica attending ph for use as th	J/Mec	IF FEMALE: 23 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy				23d. Date of deli	verv
о В	e death the atte	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		Month	Day Year
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Vital	Physician: The law this certificate has al director, page 2 a	Be Co	25. Was case referred to medical			26. Place of Death (C	1 ☐ Yes 2 🔼 N	lo 1 ☐ Yes	2 No
of <	Physic r this ce ral direc		examiner? 1 Yes 2 No 27. Manner of Death	ospital: 1 ☐ Inpatient 2 X ER/Out 28a. Date of Injury 28b. T	tpatient 3 1 DCA	ner: 4 Nursing Home			cify)
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Division of	or Atter fter des irector n by th	Certification: To	3 ☐ Suicide 6 Could not be 4 ☐ Homicide	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f.	Location (Street a	and Number or Ru ite)	ral Route Number,
7	spital o		29a. Certifier 1X Certifying Phys	ician: To the best of my knowledge	, death occurred at the t	ime, date and place, and	due to the cause	(s) and manner as	stated.
/	To the Hospital or Attend within 24 hours after death To the Funeral Director: , completely filled in by the f	Medical	one)	er: On the basis of examination and and manner stated.					
	or or co	_	29b. Signature and title of certifier	22	29c. Licens	i 966	290. L	Date signed (Month	1, Day, Year)
	10		30. Name and address of person who cor	npleted cause of death (Item 23a) (Type, Print)	. 1 - 0	Je	7 2012)
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	sity K	my poly	mie, l	Brylan	9 31718
t	Registr		JAN 0 7 2009	Sever A. Ja	ike				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 3, 2009 5:35 a^M Harry Bernard Franz, Jr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holly Hill Manor Nursing Home Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 10, Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 ₩ 2 □ F 1920 Maryland 213-14-4625 88 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Director MD Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 208 Linden Avenue 21286 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Nes 2 No If Yes, Give 143-146 Year or Dates: 43-146 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Uhite 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Contractor Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stoll P Harry Bernard Franz, Sr. Anna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Linden Ave, Towson, MD 21286 Lorraine Franz-wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Serv Corp 01/06/09 4 □ Donation 5 □ Other (Specify) Towson, MD 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 10 /v Atheros denotic (andocciscular Due to (or as a consequence of): 5 7V0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? 1□ Yes 2☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, e Funeral

To the within 2

Physician

Funeral

Director

a or

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Physician

/Medical

Baltimore, Maryland 21215-0036

/Medical

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Rm

mien - p Kinoune

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

gutan N 38. Registrar's Signature

29c. License number

4rect

03/805

Baetimys

29d. Date signed (Month, Day, Year)

2120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TITEM 170 - TEP ACTION OF Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 03 2009 Irving Glashoff, III January Howard 8:39 рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Joseph Hospital Baltimore Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Year) 1 図 M 2 □ F 220-42-9172 Yrs. 63 Director 1945 Maryland 13, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Experience round be required at Md. Baltimore Lutherville 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Gurteen Court #302 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: 1X Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2X No Specify. White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 5+ Director of Security Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Irving Glashoff, II Ruth Lvnch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 8504 Hill St. Ellicott City, Md. 21043 Mrs. Jody Callahan/ Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Mem. Park 1-9-09 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Towson Funeral Home, 1050York Rd. Towson, Md. 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause an each line Immediate Cause (Final _andiovascular **Physician** Arteniasc disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) an The law requires that the death certificate be executed burial-t Due to (or as a consequence of) physician Box 68760. Physician/Medical the attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. the a ☐Yes 2☐No 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ▶ Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 XER/Outpatient 3 □ DOA P 1 Inpatient within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar

10

29b. Signature

31. Date filed

3a) (Type, Print)

Registrar's

e Hill CT. Lutherville

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND of Maryland Perpartment of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 05/3 AM annavi 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Northwest Hospital Center Randa11stown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours 1 M 2X Dec. 22,1929 Maryland 79 Director 212-28-3931 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show er than "natural", or items 23a or 28a-f show 1 ☐ Yes XXNo Director Pikesville MD Baltimore 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21208 611 Reisterstown Rd. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. filed within 72 hours after 1 Never Married XX Married Maryland 21215-0036 1 □YesXX No Specify Specify: White ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be pe Gladys Idella Stansbury Charles Wilbert Sullivan ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sterlyn Sterling C. Green/Husband of Health a 611 Reisterstown Rd. Pikesville, MD 21208 altimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Pages 1 permit. Pages
Department of I
Important: If ite
any injury or o cemetery crematory or other Druid Ridge XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/08/09 Pikesville, MD Cemetery 22. Name and Address of FacilityEckhardt Funeral Chapel P.A. 21. Signature of Fund | Service License 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions Physician/Medical Examiner it any, leading to in module cause. Enter Underlying Cause (Disease or injury that initiated events lor Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 🗷 No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation after death.

Director: Af in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. within 2 29b. Signature and title of certific 29d. Date signed (Month. Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

ORIGINAL

Physician

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

10a State

555-01-8225

Usual Residence of Decedent

Charlotte Ruff Griffin

1218 Elm Ridge Avenue

6. Sex

1 ☐ M 2 🔀 F

4a. Facility Name (If not institution, give street and number)

10b. County

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be rediffed at once. 1 ☐ Yes 2 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 USA 1218 Elm Ridge Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🖾 No þ Specify: 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Roofing Business Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Armstrong Georgia Beall ပ္ 19a. Informant's Name/Relationship (Type. Print)
Deborah Salim Granddaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3004 Seneca Chief Trail; Ellicott City, MD 21042 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 1/9/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician erehad /Medical Due to (or as a consequence of): Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 **X**No 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑No Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 分 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. eral Director: A 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29b. Signature and tiple of certifia 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) completed cause of death (Item 23a) (Type, Print).

RACTURE 455 News of Rel do fe 100 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Months

7. Age (In yrs. last birthday)

10c. City. Town or Location

99

4b. City, Town, or Location of Death

Davs

Baltimore If Under 1 Year | If Under 24 Hrs.

Hours

Min.

Reg. No. 2009

2009

Baltimore

Maryland

4c. County of Death

5:40 PM

Birthplace (State or Foreign Country)

10d. Inside City Limits

Month

8. Date of Birth (Month, Day,

January 4,

July 16,1909

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - For Stata Regis	itrar			State o	of Mai	ryland		artmer <i>rtifica</i>				lental Hy	/gien Rag. N	711	09	00146
Physician			First, Middle Hildebi		Tr								2. Date of D Month		ay	Year	3. Time of Death
/Medical Examiner	4 5 - 10-		not institution			mber)	ITA	<u></u>	4b. City	Jown, or	Location	of Death	Janua	_	c. County	of Death	1:4gPM
Funeral Director	5. Social S 217-	ecurity N		6. Sex 1 🖾 N	M 2□F	_	(In yrs. la	st birthday, Yrs.	If Unde Months	Days	If Unde Hours	Min.	8. Date of B (Month, D Dec.	ay, Yea	923	9. Birthp Coun Mary	lace (State or Foreign try) Land
TO	Usual Res		Decedent 10b. County					, Town or L	ocation							10	Od. Inside City Limits
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ath wit	715	Maio	den Cho		~- -					1228					SA		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mantal Hyglene. Important: if item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other traumatic avant. In Medical Examinar must be mutilised at once. To Re Completed by Euroral Director	11. Marita 1 □ Ne 3 □ W	ver Marri	ed 2 ∏ Mari	ried	2. Was Dec Armed Fo 1 1 7 Yes If Yes, Gi Year or D	orces? 2 ∐ No ive	0	5. 13.	Was Dece If Yes, spo 1 ☐ Yes		ispanic O in, Mexica Specify		acify Yes or N Rican, etc.)	lo-	Blac	e - Americ ck, White, v: Whi	etc.
5-00		(Spac	15. Deceden		ition			16a. Dece	edent's Usi s kind of w DO NOT	ual Occupa	ation during mo	st of work	ing	16b.	Kind of B	usiness/Inc	dustry
Maryland 21215-0036 at 2 should be filed within 72 hours att the and Mantal Hyglene. 27 is marked other then "natural", or traumatic avent, the Madical Examiration of the Mantal Examiration of the Mantal Examinated hygleness.	Elemen		ndary (0-12)		College (-)	life.		use retired hini:			·	ma	chin	e sho	р
be filed v tal Hygie d other avant.	17. Father	's Name	(First, Middle,	Last)							18. Moth	er's Name	e (First, Middl	e, Maide	n Suman	18)	
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Aar)	19a. Infor		ame/Relations	_					-				Al Route Num				Code) e, MD 21228
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 4c, per MD 8888 2/11/09 TT
State of Maryland / Department of Health and Mental Hygiene 200 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last)
Walter Gene Johnson 2. Date of Death 3 Time of Death Month **Physician** A^{M} 2009 January 04:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Solomons Ashbury Solomons HHC Castle Calvert 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 □ F 78 479-28-9424 Yrs Director August 16 1930 Iowa Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show Calvert Solomons MD Director 1 X Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 and injury or other traumatic event, the Medical Examiner mant has never sonce. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20688 11740 Ashbury Circle Apt. 1105 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Communication Tech Navy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lois Vining Walter Johnson ္ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11740 Ashbury Circle Apt. 1105 Solomons, MD 20688 Joan Johnson/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/07/2009 Hanover, Maryland 4 Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 21. Signatur of Funeral Service Licersee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) IN /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 ☐ Yes 2 🔼 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 ⊠Natural 2 □ Accident 5 ☐ Pending investigation n 24 hours after death.

e Funeral Director: Afte bletely filled in by the fun 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hor To the Fune completely f (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and iddress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Barth 110 Hospita

31. Date filed (Month, Day, Year)

ORIGINAL

32 Registrar's Signature

Rd. Prince Frederick, MD 20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Dece tent's Name (First, Middle, Last, 2. Date of Death **Physician** tenuary arion Whoson /Medical 4b. City, Town, or Location of Death County of Death Facility Name (If not institution, give street and number) Examiner ommunite 8. Date of Birth (Month, Day, Age (In yrs. last birthday) If Under 9. Birthplace (S **Funeral** Months Days 1 □ M 2 💢 F Yrs. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modral Examinar in as be notified at once. 10b. County 1 ☐ Yes 2 No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2072 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify 2 Slac 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use paired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry edondary (0-12) College (1-4or 5+) ne (First, Middle, Maiden Su Father's Name (First, Middle, Last) Be on Zo မ mour 19b. Mailing Address (Street and Wamber or Rural Route Nun mant's Name/Relationship (Type. Mitchellville NH or MD 20721 Kings Heather D Waters U Dacqueline
Da. Method of Disposition 20a. Met 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 1.14.09 21. Signatur of Funer (21229) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metabolic ACI dosis EUGTL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 0 TU if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner eda requires that the death certificate be executed physician and s the burial-transil Due to (or as a consequence of) Box 68760, PRI Physician/Medical use as t attending p IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ clitus 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 - No 1 Depatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 09 10 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Larkam, MD. 20706 AZ662 ABIODUM 8118 Good Lucic Rd.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 19 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2059 7:22-AM 05 Edna May Johnson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Sanatitan Baltimo Baltimore City Digaett Geod If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 🗙 F 01/02/1920 Maryland 89 Director 218-05-1911 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes Ž\ No Glen Arm, Maryland Baltimore CIM Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21057 U.S.A. 11630 Glen Arm Road - G-15 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify. White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Maryland National Bank Assistant Manager 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fill h and Mental H r is marked oth Be Mary Jeannette Keener ٩ George A. Biddison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health em 27 i 9400 Perglen Road - Baltimore, Maryland Linda L. Petrush (daughter) Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of I 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Important: If it any Injury or o Gardens of Faith Cem. 01/09/2009 | Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 as 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MEUMBNIA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. physician Physician/Medical the use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 🗷 No 5 ☐ Other (specify) P.0. 9 Unknow Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 FHSION 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an 1 Yes Division or Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 21/10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: after death.

Director: After 5 Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 24 hours a Hospital within 24 hor To the Fune completely fi To the

a

7 State

31. Date filed Registrar

29b. Signature and title of certifier

2

29c. License number

29d. Date signed (Month, Day, Year)

GEOC!

ddress of resor who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day JRINGSOK me lia 200 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of D an dall 1st N0514 Date of Birth (Month, Day, You Jan. 2, (In yrs. last birthday If Under 24 Hrs Days Vear 1 □ M 2 🛣 96 1913 219-01-5184 Jan. Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 TYes 2 No Baltimore Woodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21244 USA 3424 Ripple Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 21∑ No If Yes, Give Year or Dates: Specify: White 1 ☐ Yes 2 🗷 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Security Adm. Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Adam Reifschneider Agnes Morfeld 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa M. Jacobson Daughter 25 Centrl Park West Apt 8A; New York, New York 10023 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Atlantic Crematory 1/5/2009 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Euneral Service Licensee 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1 Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Die to (or as a consequence of): disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery nt pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy months? Day Year 5 Other (specify) No **ificant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 ☐ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

items 23a or 28a-f show Examiner must be notified at

'natural", or

Hygiene.

Pages 1 and 2 should be filed in nent of Health and Mental Hygiint; If Item 27 Is marked other

permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is

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Director

Funeral

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Completed

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

the death certificate be

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Physiclan:

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Physician/Medical

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Completed

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Certification:

Medical

and as Leen signed by the attending physician 2 should be detached for use as the buries certifica e has After this To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After filled in by the

	b.	Wa in t	ALE is d he Ye	ece pas	st 1:
Pa	rt I	I. C	the	rs	ign

25. Was case referred to medical examiner' 1 Tes 2 No 1 Inpatient 27. Manner of Leath 28a. Date of Injury (Month, Day Year) 1 Natural

5 Pending investigation 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Year

30. Name and dress of person who completed cause of death (Item 23a) (Type, Print)

2 ER/Outpatient 3□ DOA 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 Homicide

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day,

82. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** EVELYN 05.20 AM 2009 06 Januar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayview Medical Center Baltimore Hopkins If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday). 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🕱 F Director 215-40-5720 18-1940 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-1 shov traumatic event, the Medical Examiner must be notified at 1 TXYes 2 □ No Director MD Baltimore Dundalk death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7538 Lawrence Road 21222 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Woodrow Wilson ဂ္ Evelyn Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. John F. Kiel, Sr.-Husband 7538 Lawrence Road, Dundalk, MD 21222 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory: 1-7-2009 Baltimore, MD 22. Name and Address of Facility
Bradley-Ashton Funeral Home, 21. Signature Funeral Service 21222 Approximate Interval Between Onset and Death 2134 Willow Spring Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final hemorrhage **Physician** Subarachnoi disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical attending plant for use as yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation n 24 hours after death.

e Funeral Director; Aft hitely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide TEX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 06, RES-0000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4540 EASTERN AVENUE BALTIMORE MD 21224 Mohamad M.D.

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death William Baxter Kaiser 2009 January 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Frederick Villa Catonsville Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) Months Days Hours 1 ★ M 2 🗆 F 216-07-8211 94 Jan. 13, 1914 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 309 Locust Drive 21228 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Was Deceded. Armed Forces? 1 ☑Yes 2 □ No WWII 1 Never Married 2 Married 1 ☐ Yes 2 █No If Yes, Give Year or Dates: Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Welder Ship Yard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ambrose Kaiser Mildred Brotherton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 309 Locust Drive; Catonsville, MD 21228 <u>Mary M. Kaiser</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1/8/2009 Atlantic Crematory Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral S ruice Li 1630 Edmondson Avenue; Catonsville Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final ard, o myopath disease or condition resulting in death)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

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Funeral

Director

1 and 2 should be filed within 72 hours after death with the Maryland

altimore, Maryland 21215-0036

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Madical Examinar must be notified at

Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, Item Maone.

Pages 1

sician and burial-trans attending physician for use as the buria icate has been sig r, page 2 should b certificate has funeral director, this After t

law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical signed by the a ģ Be Completed

Certification: To

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

lan

Strut

32. Registrar's Signature

3 Suicide

29a, Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

To the Hospital or Attending | within 24 hours after death. To the Funeral Director: After filled in by the Medical

41

State Registrar

l localiting in accum,	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Linter Underlying	b. — Due to (or as a consequence of):	
Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequence of):	
•	d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions	, , , , , , , , , , , , , , , , , , ,	Did tobacco use contribute to the cause of death? Ues 2 No 3 Probably 4 Unknown
		Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?	26. Place of Death (Check o	nly one)
1 Yes 2 Sto	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 ☐ I	Residence 6 ☐ Other (Specify)
27. Manner of Death Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Description	ribe how injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

21136

29d. Pate signed (Month, Day, Year)

DHMH 17 Rev 1/2001

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Smile

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 01:50A M KRAMER - ILLIAN 05 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY N/A EVINDALE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
PA 8. Date of Birth (Month, Day, Year, 09/12/1910 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F 218-01-7321 Director 98 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f shov notified at 1 ¥Yes 2 No Directo MD N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 6026 GREEN MEADOW PARKWAY, APT. 21209 filed within 72 hours after death v Hygiene. Ither than "natural", or Items 23s USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Completed by Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill treent of Health and Mental Hitant: If item 27 Is marked oth 18. Mother's Name (First, Middle, Maiden Surname) Be 2 KRAMER NETTIE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAY BESER/NIECE 12344 GREENSPRING AVENUE OWINGS MILLS,MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State HEBREW YOUNG MENS 01/06/2009 BALTIMORE, MD 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS. 8900 REISTERSTOWN ROAD PIKESVILLE, 21. Signature INC. 21208 23a. Part1. Enter the disease, or commiscations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or e cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** TERMINAL DEMENTA OMPLICATIONS resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by INSUFFICIONCY 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy perform 2 No Hospitai or Attending Physician: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ 1√0 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4☐ Mursing Home 5☐ Residence 6 ☐ Other (Specify) s after oc... ral Director: After ... hv the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00064533 1145101 AN 01-05-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOND ME HOSRIW Commerc un

J

Registrar

State

31. Date filed (Month, Day, Year) AN 0 7 2009

BABATUNDE

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32 legistrar's Signature

Danua B. Agai

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	Physici	an	1. Decedent's Name							2. Date of D Month JANUAR		ay	Year (2)(2)(5)	3. Time	of Death
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	or 28g	Funeral Director	10e. Street and Nun		more	1.0	LILV T.LI	10f. Zip Code			10g. C	itizen of	What Co	ountry?	
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Maryland	l 2 should be filed w h and Mental Hygie r is marked other t raumatic event, th	၉	Paul Cos		hin (Type Print)		19h Maili	na Address (Street		re Schell Rural Route Num		or Towr	State	Zin Code)	
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Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other to once.		20a. Method of Disp		3 ☐ Removal from S		Place of Dispo	osition (Name of matory or other pla	ce)	Date	20c. I	_ocation	- City or	Town, State	-
Itim	permit. Pages 1 Department of H Important: If Ite any Injury or ot		4 ☐ Donation 21. Signature of Fu			Pa		Cemeter		/06/2009 E. F. Las				Maryl	
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Вох	eath certificate be exattending physician for use as the burial	ın/Me	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outc	ome of pregna		☐ Ectopic pregnan				23d. Da	ate of de	livery	
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	Jing J. After fune	tion:	27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 ☐ Pendir investi	ig ·	h, Day, Year)	28b. Time o Injury	Wo	ıryat rk?]Yes 2 ∐ No	28d. Describe	how inji	iry occu	rred		
Division	i di di di	Certification: To	3 Suicide 4 Homicide	6 Could determ	not be nined 28e. Place building	of Injury - At hog, etc. <i>(Speci</i>	ome, farm, sti fy)	reet, factory, office		28f. Location City or To			ber or Ri	ural Route N	umber,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep	artment of Health and ertificate of Death	, ,	ene g. No.2 () () 9	00155
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medio		Evelyn M. Magee		January	Day Year 1,2009	5:00A M
-	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Dear	
-/			9 Meadow Valley Drive	Rising Sun		Cec	11
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign
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	land w		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
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	or 282	irec	10e. Street and Number	10f. Zip Code	10:	g. Citizen of What Co	L puntry?
	th wit	<u>a</u>	1423 Chestnut Street	21160		USA	
	tems tems	Funeral Director	Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
36	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dieal Examiner must be redified at	y F	1 □ Never Married 2 □ Married 1 □ Yes 2 🔯 No If Yes, Give 3 🔯 Widowed 4 □ Divorced Year or Dates:	1 ☐Yes 2 X No Specify:	, , , , , , , , , , , , , , , , , , , ,		Thite
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Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be redified at once.			ing Address (Street and Number or R			
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Ħ	artme Srtani Injury		4 □ Donation 5 □ Other (Specify) Parkwoo 21. Signature of Funeral Service Licensee	d 1-6-2 22. Name and Address of Facility Sc		Parkvill	
Ba	Depar Impor any Ir			9705 Belair Rd. No			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en				Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	NCER			Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	NCER			2 years
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	Si / G	Examiner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
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687	ificate g phy as the	edical	d				
Box	leath certific attending p	N.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of del	iverv
O. B	The law requires that the death certil atte has been signed by the attending bage 2 should be detached for use a	Physician/M	1 Yes 2 No 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
<u>Р</u>	at the d by th	h Š	9 Unknown	_			
ń	w requires that the dispersion signed by the should be detached	۵	Part II. Other significant conditions contributing to death but not resulting in the t		Α.	cco use contribute to	
0.0	requi	Completed	Chronic obstructive pulmona	ry disease	1 XYes	2 No 3 Pr	obably 4 ☐ Unknown
ခိုင	e law has t	Jp.			24a. Was an autopsy	prior to d	topsy findings available completion of cause of
a	sician: The certificate h rector, page			an agreement	perförme 1 □Yes 2 🌬		2 □No
5	sicial certi recto	Be	25. Was case referred to medical examiner? 1 ☐ Yes 25 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Othern	th (Check only one)		paughter's
ō	y Phy er this eral d	Ë	27. Manner of Death 28a. Date of Injury 28b. Time of	of 28c. Injury at	ome 5 Residence 28d. Describe how	ce 6 Other (Specinium occurred	city) résidence
0	ath. r: Affe e fun	atio	Natural 5 Pending (Month, Day, Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		,,	
Division of Vital Records,	r Atte er de∉ recto by th	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru	ral Route Number,
<u> </u>	italon rs aft al Dii led in	Cer				·	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director; p	ical	29a. Certifier (Check only color of the best of my knowledge, deal of the basis of examination and/or in the basis of e	th occurred at the time, date and place overstigation, in my opinion, death occurred	e, and due to the cau	se(s) and manner as	stated. to the cause(s)
	thin 2 the orthe	Medical	29h Signature and title of certifier	29c License number	204	Data signed (Month	Day Vaari
	F ≥ F 8		Bande Olives (U)	D 34208	290	Allas Igned (World	ay, rear,
	10		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		01/00/	7
			LINDA A WACKA MD 3718 Non	Print) Prisville Kd Suite	C, Varret	Ysuille MU	2/084
	Stat		31. Date filed (Month, Day, Year) 2000 32/ Registrar's Signature	arkel		7	
	Registra		LEGICAL TO LANGE TO THE PARTY OF THE PARTY O				

	4	For State Registrar	State of M	laryland	•	tment of H <i>ificate of L</i>		i Mental Hy	/giene Reg. No.	2009	0015
Į		1. Decedent's Name (First, Middle, L	Last)					2. Date of De Month		Year	3. Time of Death
icia dica	al .	Emma C. Mogaver						Januar			11:00P
nine	er	4a. Facility Name (If not institution, g)	4	4b. City, Town, or		ath	i	County of Death	1
		7802 Chapman Ro		ge (In yrs, last	t hirthday)	Kingsv:		rs. 8. Date of Bi		Balto.	nplace (State or Fore
ai or		212-20-8441	1□ M 2K□ F	92		Months Days	Hours Mi	in. (Month, D	ay, Year)	Cot	intry) Marvland
4		Usual Residence of Decedent		92				Бергеш	ber z	Z,1910 .	maryland
		10a. State 10b. County		10c. City, T	Town or Loca	ition					10d. Inside City Lim
	cto	Md. Ba	lto.		Kir	ngsville					1 ∐ Yes X∏ N
	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Cou	intry?
	<u>ra</u>	7802 Chapman R					21087			USA	
	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	13. Wa	as Decedent of Hi /es, specify Cuba	spanic Origin? n, Mexican, Pue	(Specify Yes or Nerto Rican, etc.)	0- 1	 Race - Amer Black, White 	
		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ∐Yes 2 XX If Yes, Give Year or Dates:	INO	10	⊒Yes 2 ∏ No	Specify:			Specify:	White
Ţ.	Completed by	15. Decedent's		11	16a. Decede	nt's Usual Occupa	ation		16b. Kir	nd of Business/I	ndustry
1	ble	(Specify only highest g	grade completed) College (1-4or	5.1)		nd of work done of NOT use retired		vorking			·
1	E O	9th	College (1-40)	57)	Homem	naker				Ho	ne
	BeC	17. Father's Name (First, Middle, La	st)				18. Mother's N	lame (First, Middle	e, Maiden s		
	P.	Henry Debelius					Elia	zabeth Fi	ceema	n	
ı.		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailing	Address (Street a	and Number or	Rural Route Numi	ber, City or	Town, State, Z	ip Code)
		Charles Henderso	n S-I-		7802	Chapman	Road F	Kingsvill	le, M	d. 2108	7
		20a. Method of Disposition 1 □ Burial 2 【 Cremation 3	☐ Removal from State	20b. Plac	ce of Disposit netery, crema	tion (Name of tory or other plac	e) :	Date	20c. Lo	cation - City or T	own, State
		4 □ Donation 5 □ Other (Spec	cify)	Bayv				-2009		to. City	
nce		21. Signature of Funeral Service Lie	ensee					Schimunel			
a	1	23a. Part 1. Enter the disease, or co	4					d Notting		Md. 212	236 Approximate
n al er	iner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b	s a consequent	nce of):	3 14	Dr 2-0	e on se			3 year
	ledical Examiner	resulting in death) Last	cDue to (or as	s a consequen	nce of):						200
	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal de	eath 3 🔲 8	Ectopic pregnancy Other (specify)	,		2	3d. Date of deli	very Day Year
	þ	Part II. Other significant conditions	s contributing to death I	but not resultin	ng in the und	erlying cause give	en in Part I.				the cause of death?
	Set							24a. Was		24b. Were aut	opsy findings availal
	Completed								ormed?	death?	ompletion of cause of
- 1	ø l	25. Was case referred to medical					26 Place of D	1 ☐ Yes Death (Check only	2 No	1 □ Yes	2 LI NO
1	∞ ∣	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpat	ient 2□EB	R/Outpatient	3 DOA Othe	r.	Home 5 Res		Other (Spec	i6A
	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Inj (Month, Date)	ury 28	3b. Time of Injury	28c. Injury Work	/ at	28d. Describe			
1.	Certification:	3 Suicide 6 Could not determine	ed 28e. Place of the building, e					City or To	wn, State)		ral Route Number,
		(Check only 2 Medical Ex	Physician: To the best aminer: On the basis and manner s	of examination	eage, death on and/or inve	stigation, in my o	pinion, death oc	ace, and due to the courred at the time	, date and	place, and due	to the cause(s)
:	edical	one)							20d Date		
:		29b. Signature and title of certifier S. Rogu 30. Name and address of person wh		n. D			053	•	Jan	e signed (Month	51= 1200

EMMA MOGAVENO DOD: 1/3/09 TOD

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Red, No. 2 1 1 9

		•	For State		Cei	rtificate of D		ental Hygi	g. No.2 () () 9	00157
			Registrar 1. Decedent's Name (First, Middle, L	ast)		imodic or b		2. Date of Death	g. No. 2 U U J	3. Time of Death
	Physici		Stanley	Mor	ney		_	Month	6 2009	12:30 A M
·	/Medic		4a. Facility Name (If not institution, g		4	4b. City, Town, or L		4	4c. County of Death	
1	LAGIIII		Northampton Mano	r Health C	are Ctr.	Free	derick			derick
	Funeral		1	Sex 7. Age	e (In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign ntry)
	Director		221–12–9281	TAM ZUT	87 Yrs.			Apr. 16	, 1921 <u>Del</u>	aware
2	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
N O D	Mary -f sh	tor	Maryland Fred	erick		Fred	derick			1⊠Yes 2□No
4	n me	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?
i i	23a c	al D	200 E. 16th S	t			21701		U.S.	,A
0	be lied within 72 nouts arter death with the maryland Hygiene. Hygiene. At Hygiene. At Hygiene. At the "matural", or items 23a or 28a-f show event, it of the thermal terminate rediffed at	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13.	Was Decedent of Hisp f Yes, specify Cuban,	oanic Origin? (Spe Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - Ameri Black, White,	
36	yor i	by F	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ⊠Yes 2 □ N If Yes, Give		1 □Yes 2 X No	Specify:		Specify:	
21215-0036	ntural MLD	ed t	15. Decedent's I	Year or Dates: 1	16a Dece	dent's Usual Occupati	ion	10	WN. 6b. Kind of Business/Ir	ite ndustrv
215	within /2 iene. than "na	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5	+) (Give	kind of work done dui DO NOT use retired)	ring most of workin		horse	
21.	e nied within al Hygiene. other than " vent, ine Mo	Con	8			essional h			oreeder/tra	iner
ind 2	d oth	Be	17. Father's Name (First, Middle, Las	,		1	8. Mother's Name	(First, Middle, Ma	aiden Surname)	
ryla	snould be and Mental s marked o umatic eve	ပ္	Wallace Veasey		10, 11, 11,			n Goddar		
Maryland	of 2 should the and th		19a. Informant's Name/Relationship Leslie Kinkead/			ng Address (Street an A Links Br:			City or Town, State, Zi nont, MD 21	
	ges I and z should It of Health and Mer If item 27 is marke or other traumatic		20a. Method of Disposition	addgireer		sition (Name of natory or other place)			Oc. Location - City or T	
Baltimore,	permir. Pages I a Department of Hec Important: If item any injury or othe once.		1 ☐ Burial 2 【A Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		1	y Crematic	i	onna s	Sykesville,	MD
Balti	permir. Fag Departmen Important: any injury once.		21. Significant of Funeral Service Lice			Name and Address			neral Home	T-ILD
<u> </u>	8 2 E E 8	1	attravine (). Law /2l	er 4	04 S. Mair	n St. W	oodsboro	, MD 21798	
			23a. Part 1. Enter the disease, or con shock, or heart failure. List onl	nplications that sed one cause on each lir	the death. Do not ent ne.	er the mode of dying,	such as cardiac or	respiratory arres	st,	Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition	_a.	rebro vo	raculor	5 tr	9712		Onset and Death
	/Medical examiner		resulting in death)	Due to (or as	a consequence of):					
		ē	Sequentially list conditions,	b Due to (or as	a consequence of):					
JC 3	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		, ,					
68760, K	physician and the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequence of):					
68760,	are or hysici the bu	edical		d						
		Med	IF FEMALE:				-			
Box	w requires that the death cells, been signed by the attending should be detached for use to	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy			23d. Date of delive	rery Day Year
P.O.	the (ysic	1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	t time of death 5 L	Other (specify)				
٠, ŧ	ned by deta	y Ph	Part II. Other significant conditions	contributing to death be	ut not resulting in the u	nderlying cause given	in Part I.	23e. Did toba	acco use contribute to	he cause of death?
rds	ulies I sign	d by	Coronow	C2 4/1 MAY	Dispons	P		1 □ Yes	2 1 No 3 □ Pro	bably 4 Unknown
	7 7 3	(i)		STATY					- T	· –
3CO	aw rey	plete	7					24a. Was an		opsy findings available
I Recol	ate has beer page 2 shou	complete						24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of
/ital Recol	ertificate has beer ctor, page 2 shou	3e Completed	25. Was case referred to medical				26. Place of Death	24a. Was an autopsy perform 1 □ Yes 2	prior to co death? No 1 □ Yes	opsy findings available ompletion of cause of
of Vital Recol	this certificate has beer al director, page 2 show	To Be	25. Was case referred to medical examiner?		ent 2 □ ER/Outpatier	2 nt 3 DOA Other:	4 Nursing Hom	24a. Was an autopsy performs 1 Yes 2 (Check only one)	prior to co death? No 1 □ Yes	opsy findings available impletion of cause of 2 \(\sum \text{No}\)
on of Vital Recol	ing rugarcan, ine law bey After this certificate has beer funeral director, page 2 shou	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Vatural 5 Pending	28a. Date of Inju (Month, Day	ry 28b. Time of	at 3 DOA Other: 28c. Injury a Work?	Nursing Homat 2	24a. Was an autopsy perform 1 □ Yes 2	prior to co death? No 1 □ Yes	opsy findings available impletion of cause of 2 \(\sum \text{No}\)
ision of Vital Recol	death	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manper of Death 1 Natural 5 Pending investigatives investigatives and some substitution of the could not the c	28a. Date of Inju (Month, Day	ry 28b. Time of Injury	at 3 DOA Other: 28c. Injury a Work? M 1 Ye	4 Nursing Hom at 2 s 2 □ No	24a. Was an autopsy perform 1 Tyes 2 (Check only one) in 5 Residen 8d. Describe how	ed? prior to ct death? 1 Yes ince 6 Other (Special injury occurred)	opsy findings available impletion of cause of 2 □ No
Division of Vital Records,	of Attention of Trystation, The rail of the Cash. Sirector: After this certificate has in by the funeral director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manper of Death 1 Natural 5 Pending investigati	28a. Date of Inju (Month, Day	ry y, Year) 28b. Time of Injury	at 3 DOA Other: 28c. Injury a Work? M 1 Ye	4 Nursing Hom at 2 s 2 □ No	24a. Was an autopsy perform 1 Tyes 2 (Check only one) in 5 Residen 8d. Describe how	prior to codeath? 1 Yes Occ 6 Other (Special injury occurred	opsy findings available impletion of cause of 2 □ No
Division of Vital Recol	of Attention of Trystation, The rail of the Cash. Sirector: After this certificate has in by the funeral director, page 2	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigating investigating the Homicide 6 Could not determine	28a. Date of Inju (Month, Da) 28e. Place of Inju building, etc	28b. Time of Injury 28b. Time	2 Other: at 3 □ DOA Other: by 28c. Injury a Work? M 1 □ Ye eet, factory, office	A Nursing Homat at 2 as 2 \[\sum No \] 2 a, date and place, a	24a. Was an autopsy perform 1 Tyes 2 (Check only one) to 5 Residen 8d. Describe how and due to the call of the cal	prior to ct death? No 1 Yes 1 Yes Other (Special Prior or Run State) use(s) and manner as	opsy findings available impletion of cause of 2 No 2 No (fy) al Route Number,
Division of Vital Reco	of Attention of Trystation, The rail of the Cash. Sirector: After this certificate has in by the funeral director, page 2	edical Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigati 6 Could not determine 2 Accident 4 Homicide 29a. Certifier (Check only one) 25. Was case referred to medical examiner.	28a. Date of Inju	ry, Year) 28b. Time of Injury 28b. Time of Inj	at 3 □ DOA Other: 28c. Injury a Work?	Aursing Homat 2 s 2 No 2 o, date and place, a nion, death occurre	24a. Was an autopsy perform 1 Tyes 2 (Check only one) are 5 Residen 8d. Describe how 8f. Location (Stree City or Town, and due to the caud at the time, dat	prior to ct death? No	opsy findings available impletion of cause of 2 No 2 No fy) al Route Number, stated. o the cause(s)
Division of Vital Records, P.O. Box To the Hosnital or Attending President The law requires that the death cer	Within 24 hours after death. To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 shou	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manper of Death 1 Natural 5 Pending investigati 3 Suicide 4 Homicide 6 Could not determine 29a. Certifier Check only 2 Medical Example 1	28a. Date of Inju (Month, Day 28e. Place of Inju building, etc Physician: To the best ominer: On the basis of	ry, Year) 28b. Time of Injury 28b. Time of Inj	oth 3 DOA Other: 28c. Injury a Work? 1 Ye eet, factory, office n occurred at the time vestigation, in my opin	All Nursing Homat at 2 s 2 \[\] No 2 s, date and place, a nion, death occurre	24a. Was an autopsy perform 1 Tyes 2 (Check only one) are 5 Residen 8d. Describe how 8f. Location (Stree City or Town, and due to the caud at the time, dat	prior to ct death? No 1 Yes Ince 6 Other (Special Prior Injury occurred) set and Number or Rur State) use(s) and manner as the and place, and due to the death? d. Date signed (Month, and the later)	opsy findings available impletion of cause of 2 No 2 No fy) al Route Number, stated. o the cause(s)
Division of Vital Recol	of Attention of Trystation, The rail of the Cash. Sirector: After this certificate has in by the funeral director, page 2	edical Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manper of Death 1 Natural 5 Pending investigati 6 Could not determine 29a. Certifier (Check only one) 29b. Signature and title of certifier	28a. Date of Injunction 28a. Date of Injunction 28e. Place of Injunctio	ry, Year) 28b. Time of Injury	ant 3 DOA Other: 28c. Injury a Work?	All Nursing Homat at 2 s 2 \[\] No 2 s, date and place, a nion, death occurre	24a. Was an autopsy perform 1 Tyes 2 (Check only one) are 5 Residen 8d. Describe how 8f. Location (Stree City or Town, and due to the caud at the time, dat	prior to ct death? No	opsy findings available impletion of cause of 2 No 2 No fy) al Route Number, stated. o the cause(s)
Division of Vital Recor	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigati 6 Could not determine 29a. Certifier Check only one) 29b. Signature and title of certifier 30. Name and address of person who	28a. Date of Inju On De de 28e. Place of Inju building, etc 29bysician: To the best of and manner sta	ry, Year) 28b. Time of Injury 28b. Time of Injury 28b. Time of my knowledge, deat f examination and/or in ted.	oth 3 DOA Other: 28c. Injury a Work? M 1 Ye eet, factory, office coccurred at the time vestigation, in my opin 29c. License r D51643	Aursing Homat 2 s 2 No 2 s, date and place, a nion, death occurred number 3	24a. Was an autopsy perform 1 Tyes 2 (Check only one) are 5 Residen and Describe how and due to the caud at the time, dat	prior to ct death? No	popy findings available impletion of cause of 2 No 2 No (fy) al Route Number, stated. o the cause(s) Day, Year)
Division of Vital Recor	of Attention of Trystation, The rail of the Cash. Sirector: After this certificate has in by the funeral director, page 2	Medical Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manper of Death 1 Natural 5 Pending investigati 6 Could not determine 29a. Certifier (Check only one) 29b. Signature and title of certifier	28a. Date of Inju con be de 28e. Place of Inju building, etc Physician: To the best aminer: On the basis of and manner sta	28b. Time of Injury 28b. Time	ant 3 DOA Other: 28c. Injury a Work?	Aursing Homat 2 s 2 No 2 s, date and place, a nion, death occurred number 3	24a. Was an autopsy perform 1 Tyes 2 (Check only one) are 5 Residen and Describe how and due to the caud at the time, dat	prior to ct death? No 1 Yes Ince 6 Other (Special Prior Injury occurred) set and Number or Rur State) use(s) and manner as the and place, and due to the death? d. Date signed (Month, and the later)	popy findings available impletion of cause of 2 No 2 No (fy) al Route Number, stated. o the cause(s) Day, Year)

DHMH 17 Rev 1/2001

within 24 hours a To the Funeral L

State

29b. Signature and

31. Date filed (Month, Day,

Registrar

DHMH 17 Rev 1/2001

heath (Itehva3a) (Type, Print 7410 - A

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			for State Registrar		State	n iviaryia		rtificate of		i ivierilai n		2009	00	159
	Physici	an	1. Decedent's Name (Firs	t, Middle, La	st)					2. Date of D Month	Da		3. Time	of Death
who	/Media		Maralea Arm							Januar	y 0	3 200		A M
-	Examir	ier	4a. Facility Name (If not in 12486 lime			mber)		Fulton	or Location of De	ath		c. County of Dea Oward	th	
	Funeral Director		5. Social Security Number 236–62–9257		Sex I□M 2□XF	7. Age (In y	rs. last birthday) 8 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		1940 1940		thplace (State ountry) St Viro	
	and w		Usual Residence of Dece 10a, State 10b.	dent County		10c.	City, Town or Lo	ocation					10d. Inside	City Limits
	//aryla	ō		ward			lton							s 2\ No
	the l	Director	10e. Street and Number					10f. Zip Code			10g. Ci	itizen of What Co	untry?	
	n with		 12486	iln Rá	1			20759				U.S.A		
	death	Funeral	11. Marital Status	<u> </u>	12. Was Dec	edent Ever in	U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin?	(Specify Yes or N	10-	14. Race - Ame	erican Indian,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, Ite Medical Examicat must be redified at once.	Completed by Fu	1 □ Never Married 2 3 ☑ Widowed 4 □ D		1 □Yes If Yes, Gi Year or D	2 XNo ve XNo		1 □Yes 2 No		erio nicari, etc.)		Black, Whit	nite	
5-	"natu	ete	15. D (Specify onl	ecedent's E y highest gra	ducation a <i>de</i> co <i>mpleted)</i>		(Give	dent's Usual Occup kind of work done	during most of w	rorking	16b. K	Kind of Business.	/Industry	
12	filed withir Hygiene. ther than int, the M	m d	Elementary/Secondary	(0-12)	College (1-4or 5+)		DO NOT use retire	(a)			73.		
0 2	filed Hyg other ent,	Be	17. Father's Name (First,	Middle, Last) 4		HOM	emaker	18. Mother's N	ame (First, Middl	le, Maider			
lan	ould be f Mental l arked of atic eve	To B	Samuel Glen	Armst	rong				Geneva	Phillip	S			
Maryland	2 should to and Men is marked raumatic	-	19a. Informant's Name/R				19b. Maili	ng Address (Street				or Town, State, .	Zip Code)	
	1 and 2 Health a em 27 is		John veasey	/Son				6 Lime Ki		Fulton,	MD 2	0759		
ore	Pages 1 nent of H ant: If iter ary or oth		20a. Method of Dispositio 1 ☐ Burial 2 ☐ Crei		Removal from	State 20t	p. Place of Dispo cemetery, crea	osition (Name of matory or other pla	ce)	Date	20c. L	ocation - City or	Town, State	
Baltimore,	t. Pag tmen tant: ijury		4X Donation 5 □ C	ther (Specia	(y)			ts Registry		7/2009		wer, Mary		
Bal	permit. Pag Department Important: I any injury o		21. Signature of Funeral	Service Lice	nsee			2. Name and Addre		Anatomy			-	
			23a Part 1 Enter the disc	ase or com	Displications that	raused the de		522 Connel				MD 210/6	Approxima	ato.
	Physician /Medical Examiner		23a. Part 1. Enter the dist shock, or heart failu Immediate Cause (Final disease or condition resulting in death)	re. List only	a		tom						Interval B Onset and	atween
	100	er	Sequentially list condition if any, leading to immedia	s,	b	(or as a cons	equence of):							
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	ding Phy h. After thi funeral o	n:T	27. Manner of Death		28a, Date		28b. Time o			28d. Describe			cny)	
ior	e ii a	atio	2 Accident	Pending	n	in, Day, rear,	, injury		Yes 2 □ No					
Division	교육	Certification:	4 Homicide	Could not b determined	buildi	ing, etc. (Spe	ecify)	eet, factory, office		City or To	own, State	,		mber,
	the Hospital hin 24 hours a the Funeral I upletely filled	Medical	(Check only 2 N	ledical Exa	niner: On the b	best of my ke basis of exam ner stated.	knowledge, deat ination and/or in	h occurred at the ti	opinion, death oc	ace, and due to the courred at the time	e, date an	d place, and due	to the cause	(s)
	5 Militing	2	29b. Signature and title of	Cel	RF	aill	les	29c. Licens	564	3	29d. Da	ate signed (Mont	h, Day, Year)	9
	1		30. Name and address of Kendell R	Faulle	nerMD	535 6	W. Taux	entur	Rd/E	Balto	MD	212	04	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 00160 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician ina anua 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner WOL Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 7. Age (In yrs **Funeral** 1 □ M 2 🗹 F Months Days Hours Min. **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Exercite must be notified at 10d. Inside City Limits 1 Yes 2 No Director MOYE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ☐Yes 2 Yes, Give 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify ğ If Yes, Give Year or Dates: 3 Widowed 4 ☐ Divorced a Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ducator Department of Health and Mental Hygis Important: If item 27 is marked other i any injury or other traumatic event, II! once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Pages 1 and 2 should be in nent of Health and Mental ဥ 19b. Mailing Address (Street and Number or Rula) Houte Number, City or Town, State, Zip Code) 21244 19a. Informant's Name/Relationship (Type. Print) (Son) Ran 1110W Road dward Windsor Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) butus 21. Signature of Fur eral Service Linesee me and Address of Falility Homes insses 21216 North 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INFARCTION MYDCARDIAL Physician 1 m medicite disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Records, þ Diabetes mellitis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Division of Vital 1 □Yes 2 No 1 ☐ Yes 2 🗌 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3037

DHMH 17 Rev 1/2001

State Registrar

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PARK HEIGHTS

21215

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert M. Cooper MV

31. Date filed (Month, Day, Year)

6503

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 5:05 A M Mary Elizabeth O'Brien 2009 January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year) Baltimore Manor Care Ruxton Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 👿 218-09-3954 88 Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it e Medical Examinational to notified a once. Director 1 ☐ Yes 2 ☑ No MD Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21204 8415 Bellona Lane, Apt. 907 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Veryl Buxton Teresa Witty ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James R. O'Brien / Son 8415 Bellona Lane, Apt. 907, Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 01-10-2009 | Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause unlead time. Approximate Interval Between Onset and Death Mon His Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) led by the attending physician detached for use as the burial Physician/Medical as IF FEMALE nse yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 - Ectopic pregnancy Month Year Day 5 Other (specify) □Yes 2 No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 certificate has been sign frector, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

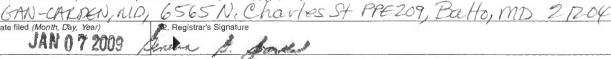
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 □Yes 2 ☑No eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O. Box 68760, within 24 hours a the 0

State

31. Date filed (Month, Day, Year) JAN 0 7 2009 Registrar

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 6, 2009 Year 6:53 Ам **Physician** Betty Nye Quinter /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Rosedale Franklin Square Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Days 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Funeral Months Days 03/09/1925 1 □ M 2 1 1 F Pennsylvania 83 198–18–9798 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 TYes XXNo Maryland | Baltimore Essex Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21221 903 Catherine Avenue Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes X2 ☐ No If Yes, Give Year or Dates: 1 Never Married XX Married 1 ☐ Yes XX No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PEMCO Corporation Secretary/ Stenographer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel Graver Thomas Raymond Nye ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 903 Catherine Avenue, Essex, Maryland 21221 Ivan Quinter, Jr. (Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State SchuykillMemorial Pk. 01/10/2009 SchuylkillHaven, Pa. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Eacility Bruzdzinski Funeral Home, P.A. 21. Signature of Fee ral pervice Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a. Part. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Instruction

Acte Myscardi L Infunction Myo condial Infanction Important diate Cause (Final diate ase or condition resulting in death) 15 minutes **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the ! attending properties for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 □ Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 9□Unknown 9 Unknown signed by to be a signed to be a detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sanile demen 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s autopsy 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ER/Outpatient 3 □ DOA 1 🔲 Inpatient P this funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After t To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After (Month, Day Year) Injury 5 ☐ Pending investigation **Natural** 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T. MAMAMEM, ~ D. SSIK-B Philadel, L. Nd., Belt, M) 21277

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JAN 0 7 2009 Janua B. Sparked

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			For State Registrar	State of Mar		epartment of F Certificate of L		nemai mygie Reg	2009	00163
	Dhysisia		1. Decedent's Name (First, Middle, Las	t)		-	-	2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Mary A. Russe					1	5 2009	830 b W
	Examin	er	4a. Facility Name (If not Institution, give	·	I COUT		Location of Death		4c. County of Deat	
anger.	Funeral		FRANKLIN SQUE	ex 7. Age	In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		holace (State or Foreign
	Director		217-12-0645	□ M 2□ X F {	36 Y	s. Months Days	Hours Min.	November	28,1922	Maryland
	and ww		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town	or Location				10d. Inside City Limits
	Maryl f sho	tor	Md. Balto			Perry Ha	11			1 □Yes X □ No
	or 28a	Director	10e. Street and Number	•		10f. Zip Code	<u> </u>	109	g. Citizen of What Co	untry?
	tth wit		8640 Jessica La	ne		21128			USA	
	er dez items	Funeral	11. Marital Status	12. Was Decedent Even Armed Forces?	er in U.S.	 Was Decedent of H If Yes, specify Cuba 	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
036	urs aft al", or vori	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 MXNo If Yes, Give Year or Dates:		1 □Yes 2 💢 No	Specify:		Specify: W	Thite
Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f show afte event, the Medical Everiling and event, the Medical Everiling.	Completed	15. Decedent's Ed	ucation de completed)	1 /	Decedent's Usual Occup	furing most of work	ting 16	6b. Kind of Business/	Industry
121	vithin	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)	, ,	ife. DO NOT use retired	1)		laimana Ii	fo Thousand
2	filed v Hygie other 1		12 17. Father's Name (First, Middle, Last)		Se	ecretary	18. Mother's Nam	e (First, Middle, Ma		fe Insurance
<u>a</u>	lid be fental ked c	To Be	Ira L. Fetterhoff				Mary	A. Burton	n	
ary	and N	_	19a. Informant's Name/Relationship (Type. Print)	19b. I	Mailing Address (Street				· _ ·
% S	and 2 lealth m 27 i		Beverly Annen		[68, 8, 45	8640 Jessi				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mardel Ever it at mist be indifficed anone.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State		Disposition (Name of crematory or other place			Oc. Location - City or	·
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ä	Dep any		> Allas	a					am, Md. 21	
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the	ne death. Do no	t enter the mode of dyir	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):				
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	nd nd	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clesaes or Injury that initiated events	C					23	
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š	n certif		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy	•□= · ·			23d. Date of de	livery
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S	w require s been sig should b	lete						24a. Was an		utopsy findings available
Division of Vital Records,	Attending Physician: The law ar death. ector: After this certificate has by the funeral director, page 2 s	Completed		-				autopsy performe 1 □ Yes 2	ed? death?	completion of cause of 2 □ No
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<u>></u>	hysic this co al dire		1 Yes 2 No			patient 3 DOA Oth	4 LJ Nursing H		nce 6 Other (Spe	ecify)
ou (ding F h. After funera	tion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day,	Year) 28b. Tii Year) Inj	ury Wor	yaτ k? Yes 2 □No	28d. Describe how	v injury occurred	
<u>IS</u>	Atten r deat sctor: by the	ifica	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	1	At home, farr	n, street, factory, office		28f. Location (Stre City or Town,	eet and Number or Ri	ural Route Number,
ă	tal or rs afte al Dir	Certification: To	4 Nornicide	building, etc.	(эреспу)			Ony or Town,	olaie)	ļ.
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending the Funeral Director, page 2 should be detached for use	Medical	29a. Certifier 1 ✓ Certifying Pt (Check only one) 2 ☐ Medical Exar	ysician: To the best of niner: On the basis of e and manner state	examination and	death occurred at the ti /or investigation, in my o	me, date and place opinion, death occu	e, and due to the ca rred at the time, da	use(s) and manner a te and place, and due	s stated. e to the cause(s)
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	ζ		31. Date filed (Month, Day, Year)	AHM ed	9000	FRANKLIN	Squar	e DR	Balto m	d 21237
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Russell

09-00078 Charles Richardso

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arles Richa	rason	1- For State	of Maryland / Depa	rtificate of			ygiche	20	09 0016
Physic	cian/	Registrar 1. Decedent's Name (First, Middle, Las		rtilicate of	Death		2. Date of Deat	eg. No.	3. Time of Death
`cal Exar			E.	D	ichards	on	Month January 3	Day Year	1126 hrs
أدر		4a. Facility Name (if not institution, give	e street and number)	4	b. City, Town, or Lo	ocation of Death		4c. County of De	eath
		2617 Loyola Northway			Baltimore				
Funera		Social Security Number 6. Se	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24Hrs Hours Min.	7	th(MM/DD/YYYY) 9. Fo	Birthplace (State or reign
Directo	or	020 00 0000	(M 2 F 74	Yrs.	World S Days	Tiours IVIIII.	02 2		Country) MD
a A		Usual Residence of Decedent 10a. State 10b. County	10c. City	/. Town or Location	on				10d. Inside City Limits
d how a	ا إ	MD NA	1 '	altimo					1X Yes 2 No
arylan	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	
the M		2617 Loyola No	orthway		21	215		USA	
eath with the Maryland items 23n or 28n-f show any	Funeral	11. Mantal Status	12. Was Decedent Ever in L		s Decedent of Hispa	anic Origin? (Sp		- 14. Race - An	nerican Indian, Black,
r death	E E	1 Never Married 2 Married	1 Yes 2 X No	IT YE	es, specify Cuban, I	Mexican, Puerto	Rican, etc.)	White, etc	
s after	<u>م</u> إ	3 Widowed 4 X Divorced 15. Decedent's Education (Specify or	If Yes, Give Year or Dates:		Yes 2X No			Specify:	Black
2 hour	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	's Usual Occupationst of working life. I	OO NOT use reti	red)	16b. Kind of Busine	ss/Industry
36 thin 7:	aldu	llth grade	na	Envir	onmetal	Servi	ce	Margar I	Mospital
5-0036 led within 7 Hygiene.	5	17. Father's Name (First, Middle, Last)		recini	161411	.Mother's Name	(First, Middle, I	Maiden Surname)	OSPILAI
21215-0036 hould be filed within 72 hours after ad Mental Hygiene. Is marked other than "natural", the nearly than "natural", the nearly than "Andrical Expension than "And	Be	Ernest Richard			М	alilda	Neal		
, MD 21215-0036 and 2 should be flied within 72 hours after death with the Maryland eath and Mernal Hygiene. eath and Mernal Hygiene. term 27 is marked other than "matural", or items 23a or 28a-f she term 27 is marked other and a constitution of a constitution of the Markad Francisco	2	19a. Informant's Name/Relationship (T		19b. Mailing	Address (Street	and Number or F	Rural Route Nun	nber, City or Town, Si	ate, Zip Code) 21223
s I and 2 sho of Health and If item 27 is	Omer trainmant	Charlene Wilki 20a. Method of Disposition		Place of Disposi	tion (Name of ceme	etery,	Date	20c. Location - City	more, 21223
nores l		1 Burial 2 X Cremation 3	- Actioval itom Gtate	crematory or oth		T = 1	16 100	Dalkins	M d
Baltimore, permit Pages I at Department of He Important: If ite	5	4 Donation 5 Other Specify: 2 Signature of Funeral Sentice Licen		22 N	ematory	of Facility		Baltimo	
Dep Dep		Asome A. 2	hompson	Ma 43	rch F/H	West	. Balt	imore, N	id 21215
Physicia	n	23a. Fart I. Enter the disease, or comp		h. Do not enter th	e mode of dying, s	uch as cardiac o	r respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
/Medica		Immediate Cause (Final disease a.	Atherosclerotic Cardio		ease				Death
			Due to (or as a consequence	of):					
	je i	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	of):					
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	of):					
50, te be executed sysician and	EX	d.	,	<u> </u>					
be exe	edical	UNPENDED	AMENDED						
760, ficate by	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pred	_		`\F-\'		23d. Date of deli	
x 687	iclar	past 12 months?	4 Pregnant at time of de	eath	al death 3 ner (Specify)	Ectopic pregna	incy	Month	Day Year
Box 6876 he death certificate y the attending phy had for use as the	Physician/N	1 Yes 2 No 9 Unknown	9 Unknown						
cords, P.O. law requires that the has been signed by	D G	Part II. Other significant conditions	contributing to death but not i	resulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
duires	ا م	The state of the s			indonying cacco giv		4 🗆 v-	2 11- 2	_
aw rec	ted by					77			Probably 4 🗹 Unknown
	pleted by						24a. Was	an 24b. Were	Probably 4 Unknown autopsy findings available to completion of cause of
Rec The I	Completed by						24a. Was autop	an 24b. Were	Probably 4 Unknown autopsy findings available to completion of cause of
ital Recicians The Issued Supported	Be Completed by	25. Was case referred to medical	fospital:,	500	26.Place o	of Death (Check	24a. Was autop perfor Yes	an 24b. Were prior death 2 1 No 1	Probably 4 Unknown autopsy findings available to completion of cause of 1? Yes 2 No
of Vital Rec Physician: The later this certificate	To Be Con	25. Was case referred to medical	Hospital: 1 Inpatient 2 2	ER/Outpatient	26.Place o	of Death (Check other)	24a. Was autop performance 1 Yes only one) g Home 5	an 24b. Were prior dealt 2 No 1	Probably 4 Unknown autopsy findings available to completion of cause of 1? Yes 2 No
on of Vital Records, ending Physician: The law requir ath. or: After this certificate has been si	on: To Be Con	25. Was case referred to medical examiner? 1 V Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	ER/Outpatient	26.Place c 3 DOA O	of Death (Check other)	24a. Was autop performance 1 Yes only one) g Home 5	an 24b. Were prior death 2 1 No 1	Probably 4 Unknown autopsy findings available to completion of cause of 1? Yes 2 No
vision of Vital Rec or Attending Physician: The I fler death. invector: After this certificate I	on: To Be Con	25. Was case referred to medical examiner? 1 Ves 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of In	26.Place of 3 DOA 0 1 1 Ye	of Death (Check ther ₄ Nursin at Work?	24a. Was autop performed autop	an 24b. Were sy prior death 2 No 1 Residence 6 Onow injury occurred	Probably 4 Unknown autopsy findings available to completion of cause of 1? Yes 2 No
Division of Vital Rec pital or Attending Physician: The ours after death. thereth Director: After this certificate.	on: To Be Con	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not determined.	28a. Date of Injury (Month, Day, Year) on be 28e. Place of Injury - At h	28b. Time of In	26.Place of 3 DOA 0 1 1 Ye	of Death (Check ther ₄ Nursin at Work?	24a. Was autop performed autop	an 24b. Were sy prior death 2 No 1 Residence 6 Onow injury occurred	Probably 4 V Unknown a autopsy findings available to completion of cause of 1.7 Yes 2 No wher: Scene
Division of Vital Rec n 24 hours after death. The Fineral Diviceor: After this certificate	Certification: To Be Con	25. Was case referred to medical examiner? 1 V Ves 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not determined 4 Homicide 29a. Certifier (Check only 1 Certifying Physici	28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At h (Specify) ian: To the best of my knowled	28b. Time of In	26.Place of 3 DOA Office Injury 28c. Injury 1 Yest, factory, office builtered at the time, date	of Death (Check other) at Work? s 2 No alding, etc.	24a. Was autop performed autop	an 24b. Were sy prior med? 2 No 1	Probably 4 Unknown autopsy findings available to completion of cause of 12 Yes 2 No wher: Scene Rural Route Number, City
Division of Vital Rec spiral or Attending Physiciau: The cours after death. reral Director: After this certificate (Tild, in by, the funcal director, page	Certification: To Be Con	25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day, Year) on 28e. Place of Injury - At h	28b. Time of In	26.Place of 3 DOA Onjury 28c. Injury 1 Ye st, factory, office builted at the time, date on, in my opinion, of	of Death (Check other4 Nursin at Work? es 2 No elding, etc.	24a. Was autop performed autop	Residence 6 One of the control of th	Probably 4 Vunknown a autopsy findings available to completion of cause of Yes 2 No wher: Scene Rural Route Number, City tated. D the cause(s)
Division of Vital Rec To the Hospital or Altending Physician: The l within 24 hours after death. To the Funeral Divicetor: After this certificate is completely filled in the this of housest after exercises.	on: To Be Con	25. Was case referred to medical examiner? 1 V Ves 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not determined 4 Homicide 29a. Certifier (Check only 1 Certifying Physici	28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At h (Specify) ian: To the best of my knowled: To the basis of examination a	28b. Time of In	26.Place of 3 DOA Onjury 28c. Injury 1 Yest, factory, office builted at the time, date on, in my opinion, of 29c. License	of Death (Check inter4 Nursin at Work? is 2 No ilding, etc. e and place, and death occurred a	24a. Was autop performed autop	Residence 6 On One injury occurred Street and Number or itate) e(s) and manner as sand place, and due to 129d. Date signed (Probably 4 Unknown autopsy findings available to completion of cause of ? Yes 2 No wher: Scene Rural Route Number, City tated. b the cause(s) Month, Day, Year)
Division of Vital Rec To the Hospital or Attending Physician: The l within 24 hours after death. To the Funeral Director: After this certificate l completely filled is be the former after-	Certification: To Be Con	25. Was case referred to medical examiner? 1 Ves 2 No 27. Manner of Death 1 Valural 5 Pending Investigation 3 Suicide 6 Could not determined 4 Homicide 29a. Certifier 1 Certifying Physici (Check only one) 2 Medical Examiner 29b. Signature and title of certifier	28a. Date of Injury - At he did (Specify) ian: To the best of my knowled and manner stated.	28b. Time of In nome, farm, stree	26.Place of 3 DOA Onjury 28c. Injury 1 Ye st, factory, office builted at the time, date on, in my opinion, of	of Death (Check inter4 Nursin at Work? is 2 No ilding, etc. e and place, and death occurred a	24a. Was autop performed autop	Residence 6 One of the control of th	Probably 4 Unknown autopsy findings available to completion of cause of ? Yes 2 No wher: Scene Rural Route Number, City tated. b the cause(s) Month, Day, Year)
Division of Vital Rec To the Hospital or Attending Physician: The leath within 24 hours after death. To the Finneral Director: After this certificate leath the Finneral Pierce or After this certificate.	Certification: To Be Con	25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day, Year) on be (Specify) ian: To the best of my knowled r: On the basis of examination a and manner stated.	28b. Time of In nome, farm, stree dge, death occurr and/or investigati n 23a) Examiner	26.Place of a DOA Onjury 28c. Injury 1. Ye the factory, office builties at the time, date on, in my opinion, of O.C.M	of Death (Check other A Nursin at Work? es 2 No olding, etc. e and place, and death occurred a number i.E.	24a. Was autop performed autop	Residence 6 One of the control of th	Probably 4 Unknown autopsy findings available to completion of cause of ? Yes 2 No wher: Scene Rural Route Number, City tated. b the cause(s) Month, Day, Year)

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month SAUVARY OSE **Physician** 2009 5 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SACTIMONE HOS PITAL RANDACUSTOWN NORTH WEST f Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min Months Days Hours Director 217-12-1730 Oct. 20, 1924 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a, State 10b. County item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes XXNo Director MD Baltimore Reisterstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 308 Holly Hill Rd. 21136 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married XXMarried Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 8 Construction Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental F should be ၉ Charles T. Ruby Edith_Josephine Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4. Pages 1 and the ment of Health an the man 27 is Constance G. Amos/Niece 708 Old Baltimore Rd. Westminster, MD 21157 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Department c Important: If any Injury or = 5 01/09/09 Finksburg, MD 4 Donation 5 Dother (Specify) Memorial Gardens 21. Signature of Free Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 mm 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No o 9☐ Unknown 9 Unknown م signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

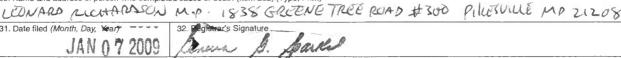
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 10 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. ours after death.

neral Director: /
filled in by the f 2 ☐ Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours at To the Funeral C 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated

State Registrar 29b. Signature and title of certifie

30. Name and address of person



who completed cause of death (Item 23a) (Type, Print)

M.P.

29c. License number

DSTIZZ

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh 887 1-13-09 vt. State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 1626 San James 09 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimo 9. Birthplace (State or Foreign Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Nary 12 M 2□ F Min. Yrs 291 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Baltimore 1 ☑Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 12/6 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 □No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: Blac 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) isabl 20 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bern 19a. Informant's Name/Relationship (Type. Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Rhonda 20a. Method of Disposition Sanders 1805 21216 lld salto, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1-14-2009 Cemeter 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Feb. of Funeral Service Licensee Funeral Homes Russ md 21216 North 23a. Part 1. Egier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Immuno deticency Due to (or as a consequence of) Immu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23d. Date of delivery nancy Month Year ify) 23e. Did tobacco use contribute to the cause of death? se given in Part I.

Physician /Medical Examiner

Physician

Examiner

10a. State

Funeral Director

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Be Completed

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Funeral

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evandrate round by notified at once.

/Medical

sician and burial-trans the as

Physician: The law requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Examiner dical

Medical

ó signed by the a page 2 he Hospital or Attending Pin 24 hours after death.

The Funeral Director: After the funeral pletely filled in by the funera Certific

Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown
Completed by Pr	Part II. Other significant conditions of	contributing to death but not resulting in the underlying cau
To Be Com	25. Was case referred to medical examiner? 1 □ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
tification:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigatio	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M
tifica	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	

				24a. Was an autopsy performed? 1 □ Yes 2 □ Wo	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No			
ed to medical			26. Place of De	eath (Check only one)				
No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 🗆 🛭	OOA Other: 4 Nursing	Home 5 Residence 6	Other (Specify)			
5 ☐ Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 □Yes 2 □ No	28d. Describe how injury	occurred			
6 ☐ Could not be determined		ome, farm, street, facto	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,			
	nysiclan: To the best of my kn miner: On the basis of examin and manner stated.				and manner as stated. place, and due to the cause(s)			

29b. Signature and title of certifier	
1001 di	
More	

(Check only one)

29a. Certifier

29c. License number D0061014

600 N. Wolfe St

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Moi

egistrar's Signature

State Registrar

completely

the the within To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year larvey Snanklin 0710 AM 7009 anuar 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Rosedale FRANKLIN SQUARE HOSPITIK Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 213-36-2399 November 12,1938 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Balto. Nottingham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13 Moray Court 21236 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Xes, Give Navy Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ☐ If Xes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Foreman Balto. Sunpapers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Audrey Murson Raymond Shanklin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patricia Shanklin Spouse 13 Moray Court Nottingham, Md. 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-6-2009 Balto. City of Faith 21. Signature of Funda Service License 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myorardiac Due to (or as a consequence of) coronary of Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy In the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Physician /Medical Examiner

sician and burial-trans

attending p

been signed by the should be detached

is certificate has director, page 2:

within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral

2

Completed

Be

Certification: To

Medical

physician

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records,

P.O. Box 68760,

Physician

/Medical

Examiner

10a. State

Md.

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

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event, the Medical Exeminer hust be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or item in item 27 is marked other than "natural", or items 23a or item in items 23a or item in items 23a or items in in items 23a or items in items 23a or items in items 23a or items in items 23a or i

Baltimore, Maryland 21215-0036

the Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

autopsy performed? Yes 2 No 1 □ Yes

1 ☐Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

26. Place of Death (Check only one)

and manner stated. 29b. Signature and title of certif

D006266

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NAMARA ROSNIUS, MD FRONCLIN SQUAR HOSPITERE ER BOLDMORE, MD 7123) 32. Registrar's Signatur 31. Date filed (Month, Day, Year)

JAN 0 7 2009

Hospital:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last)
Elbie P 5 mulh 2. Date of Death Day nd Physician 5:55P M /Medical anuar 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 1305 Lakeside 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ ₽ 220-30-6962 Yrs Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examiner roust be nufficed at once. 1 PYes 2 □ No Completed by Funeral Director Baltimore 10e. Street and Number 10g. Citizen of What Country? akeside 21218 . Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify. Specify: 3 ₩idowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) えずり Service Baltimore City Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Beryman Geneva ပ DIXOU 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mills/Dayanter 5307 Loch haven Blud Baltimore, MD 21234 20a. Method of Disposition 1 ☐ Borial 2 ☐ Cremation 3 ☐ Removal from State 1/12/2009 Baltimore 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Vayin C. Greene Funeral Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrespondents. 4905 York Ad Baitimore MD Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical attending p as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify). ned by the a P.0. 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Vital 1 □Yes 2 No Hospital or Attending Physician: 7
 24 hours after death.
 Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1∐Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA of 27. Mapner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimole, State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12:53 Ам January 2009 Norma Hynes Sotir /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson 800 Eton Road 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 🗙 F 74 053-26-2925 Director 1934 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Event in a notified at Director Baltimore Towson 1 ☐ Yes 2 ☑ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any light yor other traumatic event, the Medical Exercises 2006. U.S.A. 21204 800 Eton Road Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify. **Lhite** Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude Rvan ည George Hynes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theodore Sotir / Son 800 Eton Road, Towson, Maryland 20b. Place of Disposition (Name of Dulaney Valley Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 01-09-2009 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 22. Name and Address of Facility Ruck Towson Funeral 21. Signature Funeral Service Licensee. 1050 York Road, Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician INTERSITITIAL LUNG DISGASE ENDSTAGE /Medical Due to (or as a consequence of): Examiner FIBRILLATION ATRIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and The law requires that the death certificate be executed burial-transit RHEUMATOID ARTHRITIS Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒No 23d. Date of delivery 3 Ectopic pregnancy 0 Month Year Dav 4 Pregnant at time of death 5 Other (specify) signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ pe 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 **N**0 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier in win myms 05/2009 0055301 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

6701

31. Date filed (Month, Day, Year)

JAN 0 7 2009

DHMH 17 Rev 1/2001

SUITE 5100.

NORTH CHARLES STREET

Ruse.

32. Registrar's Signature

TOWSON MO 21204

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

35

12 Newland Rd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WArtz

MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 Certificate of Death 1, Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death JANUARY Day. 2009 2:24 John Alexander Sanders 4b. City, Town, or Location of Death 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | Feb. 27, 1914 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 1 M 2 □ F Months 212-01-8244 94 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 XNo Baltimore Towson 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? USA 21286 937 Dunellen Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? 1 ☐Yes 2 🔀 No 1 □Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Specify: Lhite ¾ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Aircraft Manufacture Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry D. Sanders Arabelle Leight 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1440 Providence Rd. Towson, Md. 21286 Ms. Patricia Bond/ Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. 1-8-09 Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Funeral Home, 21. Signature of Funeral Service Licensee 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION Due to (or as a consequence of): Sequentially list conditions, if any, had not cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a, Was an

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Md.

Funeral Director

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Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Item 15 in the Indifficult and once.

Baltimore, Maryland 21215-0036

Examiner Physician/Medical

Certification:

Medical

and the burial-tran ed by the attending physician detached for use as the burial within 24 hours after death.

To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detact ≥ Completed Be ٩

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE PROSTATE CANCER

autopsy performed? Yes 2**X** No 1 ☐ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No

25. Was case referred to medical examiner? 1 ☐ Yes 2 📆 No 27. Manner of Death 5 ☐ Pending investigation 1 💢 Natural 2 Accident

1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Injury 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

3 ☐ Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 □ Could not be

determined

29c. License number D 62312 29d. Date signed (Month, Day, Year) lanuary

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

BRANNAN, M. D. . SCOTT 7601 OSLER DRIVE, TOWSON. MARYLAND 31. Date filed (Month," Day, Year)

State Registrar JAN 0 7 2009

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Amend #30 per MD g887 1.7.09 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Year Paul Franklin Spiker 01 03 2009 8:25 AM M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b City Town, or Location of Death 4c. County of Death Air, Mar Upper Chesapeake Medical Center Maryland Harford 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☑ M 2 ☐ F Months Days Hours Min 179-24-6398 **Director** 06/18/1931 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural" or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐Yes 2 XINC Baltimore Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2501 Loloa Drive 21087 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No ģ Specify 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 shoult be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, the once. 9 Body Shop Manager Village Volvo 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 William Spiker Helen Scott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2501 Loloa Drive - Kingsville, Maryland Betty Jane Spiker (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 01/06/2009 Baltimore, Marylsand 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. مم 11750 Belair Road - Kingsville, Maryland 21087 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Perton /Medical Due to (or as a consequence of): Examiner (olon Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ischemic Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 No 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D63420 January 3,2009 person who completed cause of death (Item 23a) (Type, Print) Siddiq Z. Kharal, MD 10 Drive Bel 31. Date filed (Month, Day, Year) -State Registrar

DHMH 17 Rev 1/2001

Vital

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician /Medical Examiner

Funeral **Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Wedical Exactly at mortified at once.

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

1 - State Registrar		State of M	Cei	rtificate of		Reg.	2009	00173
1. Decedent's Name	e (First, Midd	le, Last)				Date of Death Month	Day Year	3. Time of Death
		Schueler				01/04/20		10:25 AM
4a. Facility Name (/	f not institutio	n, give street and number)			Location of Death		4c. County of Death	
5903 Lor 5. Social Security N	celey I	Seach Road 7. Ac	e (In yrs. last birthday)	White If Under 1 Year	Marsh, Ma	aryland 8. Date of Birth	Baltimor	nplace (State or Foreign
212-28-4 Usual Residence of	1050	1 X M 2 □ F	82 Yrs.	Months Days	Hours Min.	(Month, Day, Yei 02/23/192	ar) Col	ryland
10a. State	10b. County	,	10c. City, Town or Lo	cation				10d. Inside City Limits
MD	Balt	imore	White M	arsh				1 □Yes 2√∑No
10e. Street and Nur	mber			10f. Zip Code		10g.	Citizen of What Cou	untry?
5903 Tc	relev	Beach Road		21162)		U.S.A.	
11. Marital Status	or or or	12. Was Decedent Armed Forces?	Ever in U.S. 13.		ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Amer Black, White	
1 ☐ Never Marri 3🌠 Widowed		ried Yes 2	No .	1 □ Yes 2 🙀 No	Specify:	rrican, etc./	Specify:	ite
(Sna	15. Deceder	nt's Education est grade completed)		dent's Usual Occup	ation during most of work	16b.	Kind of Business/I	ndustry
Elementary/Seco		College (1-4or 5	ilfe. i	aster	during most of work f)		.S. Naval	λανθοεισ
17. Father's Name	(First, Middle	Last)		ascer	18. Mother's Nam	e (First, Middle, Maid		ACCIONALLY.
Louis St	anlev	Schueler			Fdna F	lisabeth G	laser	
19a. Informant's Na	-		19b. Mailir	ng Address (Street		ral Route Number, Cit		ip Code)
Karen S	S. Schu	eler (daught	er)_ 5903	Lorelev	Beach Ros	ad - White	Marsh. M	ID 21162
20a. Method of Disp 1 ☐ Burial 2	position Cremation	3 ☐ Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other plac	ee)	Date 20c.	Location - City or T	own, State
4 ☐ Donation 21. Signature of Fu			Metro Cro	Matory, . Name and Addre	Inc. 01/1	0/2009 Bal	timore,	Maryland Home, P.A.
0	£) 0	Land	/					and 21087
Immediate Cause (disease or condition disease or condition resulting in death) Sequentially list continue of the cause. The Under Cause (Disease or that initiated events resulting in death) I	nditions, mediate rlying dinjury	b. Due to (or as	a consequence of): a consequence of): a consequence of):		TENSIC		15 =	Onset and Death
IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ☐No	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of deli Month	very Day Year
Part II. Other signif		ons contributing to death b	ut not resulting in the u		en in Part I.			the cause of death? obably 4 Unknown
		,				24a. Was an autopsy performed' 1 Yes 2	prior to c death?	topsy findings available ompletion of cause of
25. Was case referrexaminer?		Hospital:		+ all post Other	Or:	h (Check only one)		
1 Yes 2 ☐ 27. Manner of Deatl		28a. Date of Inju	ent 2 ER/Outpatier	28c. Injur	4 ⊔ Nursing Ho	ome 5 Residence 28d. Describe how in	· · ·	eny)
1 Natural 2 ☐ Accident 3 ☐ Suicide	5 Pendi	ng (Month, Ďa gation not be 28e. Place of Inj	y, Year) Injury ury - At home, farm, str	M 1 🗆		28f. Location (Street	and Number or Ru	ral Route Number,
4 Homicide		building, et	c. (Specify)			City or Town, St	ate)	
29a. Certifier (Check only one)		ng Physician: To the best Examiner: On the basis of and manner st	f examination and/or in					
29b. Signature and	title of certifie	Parsla	U	29c. Licens	000 8	29d.	Date signed (Month	, Day, Year)
30. Name and address J.M. PA 31. Date filed (Month	ARSH+	who completed cause of cause of Cause o	eath (Item 23a) (Type, FRAN K L ar's Signature—		UARE I	P., BAL	TIMORE	MD

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009^{Year} Month **Physician** Naoma Martha Scherch 9:00a M January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 7811 Oakleigh Road Baltimore County Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) December 8 1921 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 □ F Months Days Hours Baltimore, Maryland 214 18 2424 87 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evanithat and 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Baltimore County 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21234 USA 7811 Oakleigh Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. be filed within 72 hours after 1 Never Married 2 Married 1 □Yes 2 TXNo Be Completed by If Yes, Give Year or Dates: Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) C & P Telephone Clerical Worker land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Martin Scherch Anna Helen Witt should I ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 of Health a 1241 Canterburry Drive Sykesville, Md. 21784 Herbert A Scherch Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 🖾 Cremation 3 Removal from State Metro Crematory Inc January 6 2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 Signatule of Funeral Service Licensee 23a. Part 1. Enter the diseas , or complications th shock, or heart failure. List only one caus Approximate Interval Between Opset and Death caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregrant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 Other (specify) the 1 ☐ Yes 2 ☑ No detached 9 Unknown ģ icate has been signed! page 2 should be deti 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Be Completed 1 Tes Were autopsy findings available prior to completion of cause of death? 24a. Was ar certificate has autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 \sum Nursing Home 1∐ Yes 2 12 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manual of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) -0020170 (Item 23a) (Type, Print) 30. Name and address of ause of dear 0 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** ACHEL HNIMAL 009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NON FILWEST 445 CONTE BALTIMORE RANDALLSTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Year) 1 □ M 2 🖫 F Months Days Hours Min. 218=62**-**9380 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2√☐ No Funeral Director Randallstown MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21133 U.S.A. 9960 Tuscarora Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify: Specify: Completed by 3 ☐ Widowed ♣☐ Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 2yrs Elementary/Secondary (0-12) Post Office Sorter 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jēannette Alexander ပ Carl Sheppard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1144 Pelham Wood Road, Parkville, Md Shawntelle Legrand-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a, Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Park 1/9/08 Woodlawn, Memorial 22. Name and Address of Facility
March F/n West 21. Signature of Funeral Service Licensee 21215 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Sa PSIS disease or condition resulting in death) Due to (or as a consequence of) NEUNON Sequentially list conditions, if any, leading to immediate sause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 D Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed THERENE BOGY TO 1 ☐ Yes 2 1 No 1 ☐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐Yes 2☐Mo 1 Mipatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Box 68760, attending physician for use as the buria signed by the a d be detached for ö ۵. Records, certificate of Vital director, this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral Division

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm "McCorl Eva." is a count to putfled a sonce.

Physician

Examiner

🇼 /Medical

Baltimore, Maryland 21215-0036

State Registrar

Medical

DACANDO 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

32. Registrar's Signature

CONTANTA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B

and manner stated.

29c. License number

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

		For State Registrar		State of Ma	aryland		artment <i>rtificate</i>			•	Reg. No	200	9 00	176
Physicia /Medic		1. Decedent's Name	(First, Middle, Last)	Tree	=					2. Date of D Month	eath Da	y Yea		Death M
Examine Funeral	er	4a. Facility Name (If r 5. Social Security Nur 220–18–92	mber 6. Sex	7. Ag	e (In yrs. li	a <i>st birthday)</i> Yrs.	Co J	Yea(ocation of Death If Under 24 Hrs. Hours Min.	8. Date of B	irth Day, Year)	Balt 9. E	Birthplace (State Country)	
Director wou		Usual Residence of D 10a. State		Yrs. Apr. 25					5, 1	926 Pe	nnsylvar			
ith the Mar or 28a-f s	Director	MD Baltimore 10e. Street and Number			Cockeysville 10f. Zip Code						10g. Ci	tizen of What		2 No X
filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Evarcher must be notified at	by Funeral	16 Warren Lodge Court Apt. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 2 While Status If Yes, Give Year or Dates:			Ever in U.S	ver in U.S. 13. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri			pecify Yes or N o Rican, etc.)	USA r No- 14. Race - American Indian, Black, White, etc. Specify: White				
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any injury or other traumatic event, its Medical Exagone.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry				
d be filed w ental Hygie ked other t ic event, th	To Be Co	12 17. Father's Name (First, Middle, Last) Dallas Ricketts Smith				Secretary 18. Mother's Name (First, Middle, I.d.a. Managanot Pro				e, Maider				
and 2 should be lealth and Mental m 27 Is marked on her traumatic ev	-	Dallas Ricketts Smith Ida Margaret Brinton 19a. Informant's Name/Relationship (Type. Print) August V. Treff III / son 1605 Beechwood Ave; Catonsville, MD								or Town, State				
Pages 1 ament of He annt: If Item		4 ☐ Donation	Cremation 3 ☐ Re		_		osition (Name matory or oth Cemeto		i .	Date 7/09		ocation - City kville	or Town, State	
permit. Departi Importi any Inj		21. Signature of Fund	etile	Jung		Ru		wson	Funeral		1		rk Road MD 2120	
Physician /Medical Examiner	er	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cayse on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):									tween			
icate be executed physician and s the burial-transit	dical Examiner	Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):												
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Medic	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								23d. Date of delivery Month Day Year		Year		
w requires that been signed I should be det	ed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								3e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				
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ath. or: After th	Certification: To	27. Manper of Death 1 Natural 2 Accident					Describe how injury occurred							
To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 Homicide building, etc. (Specify)								(Street and Number or Rural Route Number, own, State)				
the Hosp hin 24 hou the Funer	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										s)		
	2	29b. Signature and ti	mulus	L CRIF)		1	R05	6503		29d. D	ate signed (Mo	onth, Day, Year)	
10		30. Name and addre	Sof person who con	npleted cause of c	RNF	39	Print)	Pad	onia R	J. The	Non.	ivin M	D 21	93
Sta Registr			0 7 200g	Jan Jan Jan Jan Jan Jan Jan Jan Jan Jan	Si o Oigila	hour	20							

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amend item 1 per doc 17 per fb e887 1-7-09 vt
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** ATANISH Pete Tatanish 2009 JAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICIC FREDERICK FREDERICK mom. 1105P. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 🗆 M 2 🗆 F Months 175-16-7730 Director PENNSYLVANIA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at FLEDERUCK Funeral Director MA MONORVIA 1**/**⊡Yes 2 🗆 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Wonder Lourt 21770 USA 12. Was Decedent Ever in U.S. Armed Forces? 1. ☐Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Be Completed by Specify: Specify: LUIHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) OWNER/OFERATOR BARBER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be filk iment of Health and Mental H tant: If item 27 is marked out ANNA Tatanish ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any injury or other trauonce. 11905 Wonder Court Monorvia Nd. 21770 TAT ANISIT SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition (WWW) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MARY'S Com. 4 □ Donation 5 □ Other (Specify) RAWKY 22. Name and Address of Facility CARY L. ROLLINS FUN. I from t 21. Signature of Funeral Service Licensee 1 X. SI FREDERICK 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (g or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and (or as a consequence eral Director: After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the burial P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Dav 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2▼No 24a. Was an autopsy performe 2 No 1 ☐ Yes 25. Was case referred to medical examiner?

Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2XER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 4 hours after death. Accident 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral E 29a. Certifier 🚛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) Print) 30. Name and address of person who completed cause of death (Item 23a) (Type 32. Registrar's Signature 31. Date filed (Month, Day, Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 01-02-09 Day Joyce L. Taylor 21:22P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1□M 21¥ 59 03-24-1949 578-64-2214 DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits PG West Lanham Hills 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 7712 Frederick Rd. 20784 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐Yes AF No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Specify: Black 1 ☐Yes X☐No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working Chile DO NOT use retired) Child Care Provider 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Private Elementary/Secondary (0-12) 12th College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lola B. Haight William C. Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2017 Palmer Park Rd. Hyattsville, Md 20785 Arnice Taylor/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 01-09-2009 LANDOVER, MD 4 ☐ Donation 5 ☐ Other (Specify) HARMONY MEMORIAL 22. Name and Address of Facility Ronald Taylor II Funeral Am 21. Signature of Funeral Service Ligenses 10503 Middleport Ln.Whiteplains Md 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygienn Important: If item 27 is marked other tha any Injury or other traumatic event, If Item once.

Physician

/Medical

Examiner

10a. State

Funeral

Director

'natural", or items 23a or 28a-f show dical Examiner must be notified at

Director MD

Funeral

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Completed

Be

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

sician and burial-trans inding pl sign be page within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The

Immediate Cause (Final disease or condition					
resulting in death)	Due to (or as a consequence of):	end do			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): C. Due to (or as a consequence of): C. hvenic liver de	cses (EtoH)			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year			
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown			
		24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No			
25. Was case referred to medical	26. Place of Death (C	Check only one)			
examiner? 1 ☐ Yes 2 🌠 No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)			
27, Manper of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work? 28c. Injury at Work? 1 \[\] Yes 2 \[\] No	Describe how injury occurred			
3 Suicide 6 Could not 4 Homicide determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my knowledge, death occurred at the time, date and place, and aminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)			
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Pay, Year)			

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav 12:45P M JACOB **TANNENBAUM** JANUARY 2009 4. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death TOWSON 17 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 02/22/1919 GILCHRIST HOSPICE CARE BALTIMORE If Under Age (In yrs. last birthday) (State or Foreign **1** M 2 □ F Months 89 NY 057-14-1315 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2√☐ No BALDWIN BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21013 USA 4711 CARROLL MANOR ROAD 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Never Married 2 Married 1 □Yes 2 No Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **ABRAHAM TANNENBAUM** LINA WEINTRAUB 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARRIE TESTA / SISTER 901 CAMARO WAY FREMONT. CA 94539 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) NEW MONTEFIORE CEA 01/05/200g PINELAWN. NY of un Service Ocens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE. 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Neeks Va Due to (or as a consequence of) ementi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

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Examiner

Completed by Physician/Medical

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Medical Certification: To

Funeral

Director

show

if than "natural", or items 23a or 28a-f show the Medical Examiner must be nothed at

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itel any Injury or other traumatic event, Ite Medical Exami

Baltimore, Maryland 21215-0036

with the Maryland

burial-tran physician the attending properties for use as as signed by the a certificate has the cirector, page 2 sl To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

1 X Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

autopsy performe 1 ☐ Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🗆 No

6 Kother (Specify) HOSpic

			26. Place of Dea	ath (Check only one)
ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 □ DOA	Other: 4 Nursing H	lome 5 ☐ Residence
28a. Date of Injury (Month, Day Year)	28b. Time of Injury	280	. Injury at Work?	28d. Describe how in

27. Manner of Death

5 Pending investigation 6 ☐ Could not be determined

М 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Suite 209 Baltimore md 21204

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Doberman Danielle 6565

31. Date filed (Month, Day, Year) State JAN 07 Registrar

32. Degistrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician /Medical 4b. City, Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) ge (In yrs. last birthday) **Funeral** Min 1 M 20 **Director** 10b. County 10c. City, Town or Location 10d. Inside City Limits show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Director 28a-f 10g. Citizen of What Country? and Number 6 23a Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐Yes 2 No If Yes, Give Year or Dates: within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ ivorced "natural", 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) is marked other than con ary (0-12) College (1-4or 5+) Le 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) Be Mental ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 Health and 19a. Informant's Name/Relationship (Type. Print) 27 Gwynn Ca HIAMS 20b. Place of Disposition (Name of cemetery, crematory or other Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot Pages 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (5 5 ☐ Other (Specify) Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of swing, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease Immediate Cause (Final **Physician** LOWER ANSTRO INTESTINAL BUTTING disease or condition resulting in death) MAYS LOWER /Medical Examiner HEPATOCELLUIAR MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) HEPATITIS and Due to (or as a consequence of): Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. | 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by CHRONIC KIONEY DISEASE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an NEUROFIBROMATOSIS this certificate has autopsy 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No after death 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Implementable Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

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State Registrar

JAN 0

DANIEUE DOBERMAN, MO 6565 NOHALLES ST, SUITE 209 BALTIMORE, MO 21204
31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D64395

JANUARY 6,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 John Joseph ward January 2:00 a M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Avondale Assisted Livino Bel Air Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 17, 1917 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days 1 ☑ M 2 □ F Hours Min. Maryland 213-05-4280 Aüg 91 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Harford Bel Air 1 ☐ Yes 2 ☑ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1303 L Scottsdale Drive 21015 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2X Married 1 ∐Yes 2XX No Specify: uhite 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Route Salesman Dairy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hugh Μ. ward Agnes Hanlon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred E. ward-wife 1303 L Scottsdale Dr., Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Surial 2 □ Cremation 3 □ Removal from State Parkwood Cemetery 01/07/09 Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc./ William G. Dau 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final con disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical **Examiner**

permit. Page Department of Important: If any injury or once.

Physician

/Medical

Examiner

Funeral Director

Completed by

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, I'm Medical Examinar must be notified at

Baltimore, Maryland 21215-0036

and burial-transit the attending phase as the ed by the a signed I icate has been si , page 2 should t certificate director, this After this funeral c To the Hospital or Attendle within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Hospital or Attending Physician: The law requires that the death certificate be executed

death.

Division of Vital Records,

P.O. Box 68760

Examiner Physician/Medical Be Completed by 25. Was case referred to medical Medical Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 Unknown

autopsy performed? Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one)

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No

1□Yes 2□	10	Hospital: 1 Inpatient 2	P ☐ ER/Outpatient	3 🔲 I	DOA Other: 4	I ☐ Nursing H	ome 5 Residence 6 Other (Specify)
27. Manner of Death 1 Natural 2 Accident	5 Pending investigation		28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes		28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined		t home, farm, stree ecify)	t, facto	ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

29c. License number 29d. Date signed (Month, Day, Year)

032251

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) JAN 07 2009

29b. Signature and title of certifier

32. Registrar's Signatur

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Jon 21.570 2009 Alice Williams /Medical 4c. Counfy of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Fyaminer If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Cento 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 Ø F 74 34 Director 215-30-6707 04 16 VA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10a. State 10b. County th and Mental Hyglene. ?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Yes 2□No Baltimore Director MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 U.S.A. 3819 Belle Ave Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 □ Yes 🐉 □ No Specify à Black 3 ☐ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Technician Sinai Hospital 9th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Blanche Marshall Anderson Asher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health 814 Benninghaus Road, Baltimore, Md 21212 Jackie Jackson-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 and Department of He Important: If Item any Injury or othe 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland National 1/9/09 Laurel, Md 22. Name and Address of Facility
March F/H West 21. nature of Funeral Service Licenses 4300 Wabash Ave, Baltimore, Md 21215 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, allure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the shock, or heart Immediate Cause (Final **Physician** disease or condition resulting in death) ANCYIC Encertelaporty /Medical Due to (or as a consequence of): Examiner Annue - Con Dine Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-transit Due to (or as a consequence of): and Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the should be detached 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes □□□ No 24a. Was an page 2 s autopsy 2 No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes 2 No Certification: To 28c. Injury at Work? 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death after death. I Director: After t Hospital or Attending 1 Natural (Month, Day Year) Injury Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. within 2. To the I To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year)

State Registrar

DHMH 17 Rev 1/2001

State 31. Date filed (Month, Day, Year)

JAN 0 7 2009

32. Registrar's Signature

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Allentee

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D2908

Jon

2009

Baltimore, Maryland 21215-0036

P.O. Box 68760,	or Attending Physician: The law requires that the death certificate be executed	Directors there this certificate has been signed by the attending physician and in by the tuneral director, page 2 should be detached for use as the burial-transit.
Division of Vital Records, P.O. Box 68760,	for Attending Physician: The law	arise towart. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be defached for use as the burial-trar

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	•	For State Of Williams Registrar	-	Certificate of I			on No S & S	0 00100
		1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th Day Ye	- Or Hillo-Or Boath
Physicia /Medic		Herbert Stanley	Woli			Januar	y 6, 200	09 11:45 № M
Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	r Location of Death		4c. County of [
Funeral			ge (In yrs. last birti	ESSEX hday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Baltin	Birthplace (State or Foreign
Director		216–16–1141 1\(\overline{X}\) ¹ \(\overline{X}\) ^M 2□ F	86	rs. Months Days	Hours Min.	(Month, Day 10/12/		Maryland
pui M		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town	or Location				10d. Inside City Limits
Aaryla f sho	ō							1 □Yes 2 XNo
r 28a-	Director	Maryland Baltimore 10e. Street and Number	Dundal	10f. Zip Code		1.	10g. Citizen of Wha	t Country?
th with	a D	2211 Searles Road		21222		1	U. S. A.	
r dear	Funeral	11. Marital Status 12. Was Decedent Armed Forces	?	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, V	American Indian, Vhite, etc.
rs afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	1943	1 □Yes 2 XNo	Specify:		Specify:	White
2 hou	ted	15. Decedent's Education	1940 16a.	Decedent's Usual Occup	pation	sin -	16b. Kind of Busin	
thin 7 ne. nan "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	5+)	(Give kind of work done in life. DO NOT use retired	during most of work d)	arig		
led wi Hygier her th	ပ္ပိ	12. Father's Name (First, Middle, Last)	El	ectrician	19 Mothor's Nam	o (First Middle	Ship Yar Maiden Surname)	d
d be fi	Be					ine Mar		
should and Me mark	ပ	Paul Edward Wolinski 19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing Address (Street				te, Zip Code)
and 2 salth a n 27 is er trai		Beverley Brasile (Niece)	20	East Orvil	le Road,	Baltimon	re, Maryla	and 21221
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Ever instrument to institute at once.		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State	3	Disposition (Name of y, crematory or other plac		Date	20c. Location - City	or Town, State
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permi Depai Impo any ir		21. Signature of Fugeral Service Licensee		22. Name and Addre Bruzdzinsk 1407 Old E		L Home P.	Α	1
		23a. Part 1. Enter the disease, or complications that cause	ed the death. Do n			or respiratory ar	ssex, Mar rest,	yland 21221 Approximate Interval Between
Physician		shook, or heart failure. List only one cause on each Immediate Cause (Final disease or condition	line.	nontia				Onset and Death
/Medical		resulting in death)	s a consequence o	f):				
Examiner	<u>_</u>	Sequentially list conditions, bb.	s a consequence o	.\$\.				
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eath c atten	cian	in the past 12 months?	2 ☐ Fetal death at time of death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	су		23d. Date o Month	Day Year
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	Co	OF Man anno referred to madical				1 □ Yes	2 No 1 □	Yes 2 □ No
Attending Physician: or death. ector: After this certific by the funeral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No Hospital: 1 ☐ Inna	tient 2 ☐ ER/Ou	tpatient 3 DOA Oth	26. Place of Dea		ience 6 ☐ Other (Specify)
ding Phy h. After thi funeral o	n: T	27. Manner of Death 28a. Date of In	jury 28b. T	ime of 28c. Injury Wor			now injury occurred	5p33ii))
tendir eath. or: At	catic	2 Accident investigation		M 1 🗆]Yes 2□No			
or At after d Direct in by	Certification: To	dotormined 286, Place of II	njury - At home, far etc. <i>(Sp</i> ec <i>ify)</i>	m, street, factory, office		28f. Location (S City or Tow		r Rural Route Number,
spitał lours a neral I		29a. Certifier 1 X Certifying Physician: To the bes	t of my knowledge	, death occurred at the ti	ime, date and place	, and due to the	cause(s) and mann	er as stated.
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Medical	(Check only one) 2 Medical Examiner: On the basis and manner s		d/or investigation, in my o	opinion, death occu	rred at the time,	date and place, and	due to the cause(s)
Vithi Vithi Com	Ž	29b. Signature and titlg of certifier	A	29c. Licens	1 .	7	29d. Date signed (A	(onth, Day, Year)
DX)		30. Name and address of person who completed cause of	death (Item 23a) (1D DO		7 1	117/	04
7		Chukwuma Ebo, 1	124 N	1uce Av	enke,	salt	more,	MD 21221
Sta Registr		31. Date filed (Month, Day, Year) 32 Aegis	trar's Signature	backet	,			
negisti	an	UNIVU 1 2003 JOERSE	Ja. 1					

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ALZAMORA CHARLES Month Day **Physician** 11:41 AM JANUARY 2009 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPITAL HARBOR 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/12/1925 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1⊠M 2□ F Hours 079-18-8655 83 Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Modical Examinar must be notified at Director 1 ☐ Yes 2 ☑ No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 306 Frankle St. 21225 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 2 Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No white ģ If Yes. Give Specify. Specify: 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Refinery es 1 and 2 should be filed w of Health and Mental Hygie fitem 27 is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carlos Alzamora Maria Garcia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Lisa M. Ward / daughter 306 Frankle St.; Baltimore, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory 1/10/2009 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Mo/357 Services; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAILURE **Physician** UNKNOWN /Medical Due to (or as e consequence of): Examiner PNEUMONIA UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: attending physician and for use as the burial-transit the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnency
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐Yes 2 No 1 ☐ Yes 2 🗷 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🛭 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD mar 2 8 41 RESOCI JANUARY 07 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PEYMAN SHIRANI 3001 SOUTH HANOVER STREET BALTIMORE MARYLAND 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2009 00186 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009^{Year} Month Day **Physician** 1 ASH 8:52 P M HOMAS January /Medical Facility Name (If not institution, give street and number)
1819 Kinship Road 4b. City, Town, or Location of Death Baltimore 4c. County of Death
Baltimore Examiner 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1**¥** M 2 □ F 217-46-2440 61 Director Feb. 23,1947 Maryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show event, the Medical Examiner must be nutified at Baltimore 1 ☐ Yes 2 No Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 1819 Kinship Road U.S.A. 21222 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No If Yes, Give Year or Dates: items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 □Yes 2√√No Specify: White ģ Specify: 3 Widowed 4 XDivorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 8 ith and Mental Hygier
7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas F. Ash, Sr. Doris Luella Robinson ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 3025 Lavender Ave., Baltimore, MD 21234 Amber Valenzuela (daughter) permit. Pages 1 and:
Department of Health
Important: If Item 27
any Injury or other tr.
once. 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crmatory 1/12/2009 Glen Burnie, MD 5 ☐ Other (Specify) 4 Donation Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. <u>3631 Falls Road, Baltimore, Md 21211</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CHRONIC OBSTRUCTIVE PULMONARY Immediate Cause (Final **Physician** disease or condition resulting in death) DISGASE /Medical Due to (or as a consequence of): Examiner DRONARY AKT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician sthe burial Physician/Medical attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 □Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27: Manner of Death 28c. Injury at Work? After 1 Natural
2 Accident 5 Pending investigation after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D64116 2009 JANUARY (0 MD

State Registrar 4940

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

BALTIMORE, MD

21234

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUE

32. Bigistrar's Signature

EASTERN

JAN 08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 9 0 0 9 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 2009 Day **Physician** Joyce D. Burrell 12:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1806 N. Carey Street Baltimore Birthplace (State or Foreign Country)
 MD 8. Date of Birth 4–6–1951 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Months 1 □ M 2 🗓 F Days Hours Min. 216-58-3987 57 Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a, State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any hjury or other traumatic event, the Medical Examinar in ust be notified at once. 1
▼Yes 2□No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1806 N. Carey Street 21217 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2√No If Yes, Give Year or Dates: Specify. þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Baltimore Housing Auth. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Holmes Nellie Parham မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1806 N. Carey Street Baltimore, MD. 21217 Tyrone L. Burrell - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Mt. Zion Cemetery 1-9-2009 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 🗆 No 1 □ Yes Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 □Yes 2 □ No investigation 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Testifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Box 68760, Division of Vital Records, P.O. within 24 hours after death

To the Funeral Director:
completely filled in by the f

2

Baltimore, Maryland 21215-0036

State Registrar

29a. Certifier

29b. Signature

(Check only one)

nd title of certifier

address of person who completed cause

cal

Medic

of death (Item 23a) (Type, Print)

32. Registrar's

29c. License number

29d. Date signed (Month, Day, Year)

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09-00155	
Robert Brogden	

bert Brogden		State of Maryland / Department	of Heal	Ith and M			linie	200	9 0018
		1- For State Certificate Registrar	of Deat	th			g. No.		
Physicia edical Examir	n/ ier	Decedent's Name (First, Middle,Last) Programmer Therefore				2. Date of Death Month January 6,	Day	Year	3. Time of Death 1025 hrs
		Robert F. Brogden 4a. Facility Name (if not Institution, give street and number)	4b. City,	Town, or Loca	tion of Death	our ruary of		County of Death	
1		714 North Fulton Avenue Room #4	Baltir	more	6. Ph			1.3	Car ST REST
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	/) If Und Month	$\overline{}$	Under 24Hrs Hours Min.	8. Date of Birtl	`	DD/YYYY) 9. Birt Foreig	hplace (State or
Director		218-62-5354 1 _X M 2 _F 52	Yrs.	hs Days 1	Hours Will.	7-28-19	56		entry) MD
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ncation						10d. Inside City Limits
* .		MD Baltin							1 X Yes 2 No
daryland 28a-f show 1 at once.	cto	10e. Street and Number		p Code		10	g. Citiz	en of What Cour	
	Funeral Director	714 N. Fulton Ave		1217			-	USA	
342 ath with the items 33 of sixt be notified	<u>ra</u>	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Deced	ent of Hispani		ecify Yes or No-		14. Race - Americ	can Indian, Black,
death	nue	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, spec	ify Cuban, Me	exican, Puerto	Rican, etc.)		White, etc.	
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5-00; ed with tygiene other t	ĕ	17. Father's Name (First, Middle, Last)	:L	18.M	fother's Name	(First, Middle, M		J. Transpo	rtation
21215-0036 Juld be filed within 72 Mental Hygiene, marked other than c event, the Medical	Be C	William Brogden		Ma	ary Smit	n		,	
21 ould b d Mer s mar	٥	19a. Informant's Name/Relationship (Type, Print)	ailing Addres	s (Street and	d Number or F	Rural Route Num	ber, Ci	ty or Town, State	Zip Code)
MD 3 short alth and alth and are 27 is an animatic						nore, MD 2			
or Hear tri		20a, Method of Disposition 20b. Place of Disposition Removal from State	sposition (Na or other place		ry,	Date	20¢. L	Location - City or	Town, State
imor Pages nent of lant: If or other		4 Donation 5 Other Specify: Mt. Zion	Cemete	ry	1-14	4-2009	Lans	sdowne, MD	
Baltimore, MD 2121 permit. Pages I and 2 should be f Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,				d Address of F					
	-1	#334-Part I. Enter the disease, or complications that caused the death. Do not ent				N. Gilmor			Approximate Interval
Physician /Medical		failure. List only one cause on each line.		or dying, sooi	11 03 0010100 0	respiratory unit	, o, o, o	on, or riour	Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Cocaine intoxicatio Due to (or as a consequence of):	n			_			Boati
		Sequentially list conditions, b							
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause							
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tox 68760, eath certificate be attending physicifor use as the buri	/Me	IF FEMALE: 23b. Was decedent pregnant in the	1 -					. Date of delivery	
certifications as	cian	past 12 months? 1 Live birth 2 4 Pregnant at time of death 5	Fetal death Other (Spe		Ectopic pregna	incy		Month E	Day Year
Box e death c	Physician/Me	1 Yes 2 No 9 Unknown g Unknown	Other (op						
P.O. s that the gned by (e detache	by PI	Part II. Other significant conditions contributing to death but not resulting in t	the underlyin	ig cause given	n in Part I.				the cause of death?
S, P.C.									ably 4 Unknown
ords, w requir	plet	i				24a. Was a autop	sy	prior to c	topsy findings available completion of cause of
Record The la	Completed					perfor 1 Yes	med? 2 ✔ N	death?	s 2 No
of Vital Records, ag Physician: The law require ther this certificate has been si meral director, page 2 should be	Be	25. Was case referred to medical examiner?			Death (Check	only one)			
Physic r this	ို	1 Yes 2 No Tospital 1 Inpatient 2 ER/Outpat		DOA Othe				nce 6 🗸 Other	: Scene
n of	<u>=</u>	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day,Year) 28b. Time (Month, Day,Year)		28c. Injury at	2 X No	28d. Describe h	iow inju	iry occurred	
SiO Atten r deatl ector: by the	cati	2 Accident Investigation FD 1/6/09 FD 9:	55 am				treet a	nd Number of Pu	ral Route Number, City
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Certification:	determined (Specific) found a			ing, etc.	or Town, S	tate) /	14 N. Fi	ilton Ave
Dj e Hospital o 24 hours a e Funeral I letely filled		29a. Certifier 1 Continue Physician. To the best of my knowledge death of	occurred at th	ne time, date a	and place, and				
the plet	Medical	one) 2 Medical Examiner: On the basis of examination and/or inves							
To With	Me	and manner stated. 29b. Signature and title of certifier	29	oc. License nu	ımber		29d. l	Date signed (Mo	nth, Day, Year)
0		Dr. mo, 2, m		O.C.M.E	Ξ.		Jan	uary 7, 2009	
2 - 31		30. Name and address of person who completed cause of death (Item 23a)					L		
o plu			111 Penn	Street, Ba	altimore, M	D 21201			
C+	ata	31. Date filed (Month, Day, Year) 32. Registrar's Signature							

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DHMH 17 Rev 1/2001 OCME 2006

Registrar

DHMH 17 Rev 1/2001

State

Registrar

Jarke

9 UN CATON AVENUE, BALTIMORE, MD 21229

DURGA DHOT ADHIKARI

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 10:50 AM 2009 January SELWYN Υ. BROADNAX-BEY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death . 4c. County of Death **Examiner** Bultmore Baltimore of ity Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1XXM 2□F Months Director APR. 22 1961 MARYLAND 218-62-2395 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits show permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, if a Madical Exycological internation to prove any place. Director 1 XYes 2 No MARYLAND BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5513 GYWNN OAK AVENUE 21207 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1XXNever Married 2 ☐ Married 1 ☐ Yes 2\(\times\)No Specify. Specify: BLACK δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BARBER 12th grade HAIR-CARE Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ JOHN BROADNAX MATTIE MITCHELL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thurman D. Broadnax/Cousin 3295 Sudlersville South, Laurel Md., 20724 Baltimore, Patient 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 01-05-09 BALTIMORE, MARYLAND 22 Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. WILLIAM C BROWN COMMUNITY FU 1206 W NORTH AVENUE

23a. Dent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Colon Cancer one month disease or condition resulting in death) / /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to jor as a consequence of law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month 5 Other (specify) P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed taill 24b. Were autopsy findings available prior to completion of cause of death? Kenai 24a. Was an autopsy performed?/ Yes 2 2 No certificate 2 1 No Division of Vital 1 ☐ Yes Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending the Funeral Director: Af 1 ☐Yes 2 ☐No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

State Registrar MUMMANA

31. Date filed (Month, Day, Year)

Bradnux

Seinyn

as

Hospital of Baltimore

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

		-	For State Registrar	State of M	aryland /	Department o Certificate	of Health and of Death		giene Reg. No. 2009	00191
	Physicia	an	1. Decedent's Name (First, Midd					Date of Dea Month	Day Year	3. Time of Death
1	/Medic		Ruth Anna	Bohle			- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	01	4c. County of Death	
d	Examin Funeral Director		4a. Facility Name (If not institution Frankly) S 5. Social Security Number 217–05–3234	quare Hosp	ital le (In yrs. last bi	irthday) If Under 1	yn, or Location of Deat OSCACE fear If Under 24 Hrs ays Hours Min	8. Date of Birtl	Baitin	
	D		Usual Residence of Decedent							40 d Amilda Cita I India
	srylan show	_	10a. State 10b. County			vn or Location				10d. Inside City Limits 1 □Yes ※□No
	he Ma	Director	MD Ann	e Arundel	Gren	Burnie	ode		10g. Citizen of What Cou	
	with t	흐	1002 Dumbarto	n Pond			060		U.S.A	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Marital Hygiene. If item 27 is marlied other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Expriser must be notified at or other traumatic event, the Medical Expriser must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	12. Was Decedent Armed Forces? ried 1 □ Yes 2 ▼		13. Was Deceden If Yes, specify 1 □ Yes 2 ₹	t of Hispanic Origin? (: Cuban, Mexican, Puel No <i>Specify:</i>	Specify Yes or No- rto Rican, etc.)		
2-0	72 hou natura fichi E	Completed	15. Decede	nt's Education est grade completed)	166	a. Decedent's Usual C	ione during most of wo	orking [16b. Kind of Business/I	ndustry
121	/ithin /ine.	m p	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NOT use i	etired) maker		Own H	OTTLE
	filed within Hygiene. other than '		12 17. Father's Name (First, Middle	, Last)		Home		me (First, Middle,	Maiden Surname)	
Maryland	should be fill and Montal H s marked off	To Be	Albert E.	Jenkins			Mildre	ed G.	Matthews	
arý	2 shou and M is mar aumat	-	19a. Informant's Name/Relation	ship (Type. Print)	I .				er, City or Town, State, Z	
	1 and 2 Health a em 27 is	9	Mr. Daniel Boh	le / Son		811 Joppa		Joppa		
Baltimore,	permit. Pages 1 am Derartment of Heal Important: If item 2 am injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (1	of Disposition (Name ery, crematory or othe ntic Crema	tory 01-	-07-2009	20c. Location - City or T	ie, MD
Balt	permit. De art Import any inj		21. Signature of Funeral Service	Licensee	701479		Address of Facilits in	40	uneral & Cr Burnie, MD	emation Srv 21061
	eath certificate be executed attending physician and true as the burial-transit	edical Examiner	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Singuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence	(√ f): ∋ orj:	neumbhia	, Muiti	ləbar	Interval Between Onset and Death
.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 No 9 □ Unknown		e of pregnancy 2 □ Fetal dea at time of death	th 3 ☐ Ectopic pre 5 ☐ Other (spec			23d. Date of del Month	very Day Year
rds, P.	quires that the de in signed by the a lid be detached f	þ	Part II. Other significant condi	ions contributing to death l	out not resulting	in the underlying cau	se given in Part I.		obacco use contribute to Yes 2□No 3□Pr	
of Vital Records,	: The law requir cate has been s page 2 should I	Completed						24a. Was autop perfo 1 □ Yes	osy prior to o rmed? death?	topsy findings available completion of cause of 2 □ No
Vita	siclan: The certificate rector, pag	Be	25. Was case referred to medic examiner?	Haspital: #			Othor	eath (Check only o		
on of	ding Physiclan: The After this certificate h funeral director, page	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend	28a. Date of Inj	ury 28b	Outpatient 3 DOA Time of 28c Injury M	4 □ Nursing Injury at Work? 1 □ Yes 2 □ No	1	dence 6 Other (Spechow injury occurred	oify)
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification: To	3 Suicide 6 Could	not be 28e. Place of In	jury - At home, tc. (Specify)	farm, street, factory, o		28f. Location (5 City or Tov	Street and Number or Ru wn, State)	ral Route Number,
	Hospita 24 hours Funeral	Medical C	29a. Certifier 1 Certify (Check only 2 Medica	ing Physician: To the besing Examiner: On the basis and manner s	of examination	ge, death occurred at and/or investigation, in	the time, date and pla my opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the within To the compl	Me	29b. Signature and title of celvif	Pr / L		29c. l	icense number		29d. Date signed (Monti	n, Day, Year)
			>	4MD		ī	006257	3	1-06-	2009
_	9		30. Name and address of person Debra Hutter 31. Date filed (Month, Day, Yea	15 9000 F	death (Item 23a	(Type, Print)	2 Drive	Baltir	nose, md	21237
	Sta Registi		JAN 08	2009	1 10. 1	GI CASTON				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-00069 State of Maryland / Department of Health and Mental Hygiene Aaron Bergum 2009 00192 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month January 3, 2009 0540 hrs Medical Examiner Bergum Haron 4c. County of Death 4a. Facility Name (if not institution, give street and humber) 4b. City, Town, or Location of Death Baltimore University Hospital * Funeral 9. Birthplace (State or 8. Date of Birth(MM/DD/YYYY) 6. Sex 7. Age (in yrs. last birthday) If Under 1 Year | If Under 24Hrs. 5. Social Security Number Hours Months Days Director Country) 1 LM Yrs 25 12-21-6059 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 LYes 2 23a or 28a-f show be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 9119 0 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married Yes Yes 2 LNo specify: Specify: White Widowed Divorced If Yes, Give Year ò 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) than the Medical 21215-0036 tion Construction Department of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) e Irene annino 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print Baltimore, MD alen Ct 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State Pages 1 Crematoru Donation 5 Other Specify: 22. Name and Address of Facility Signature of Funeral Service Licensee Midvalle complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Part I. Enter the disease, or Physician Between Onset and ailure. List only one cause on each line. /Medical Death a. Hanging Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit so the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical 1-13-09 vt UNPENDED x AMENDED 16b per fh g887 signed by the attending physician be detached for use as the burial -Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown þ Completed 24b. Were autopsy findings available 24a. Was an After this certificate has been a prior to completion of cause of autopsy performed? death? 2 Νo ✓ Yes 2 1 V Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: Residence 6 Other Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 1 V Yes ۵ No 28d. Describe how injury occurred 28a. Date of Injury FOUND: FOUND 28c. Injury at Work 28b. Time of Injury 27. Manner of Death Certification: Subject hanged self FOUND: Natural 1 Yes 2 ✔ No Pending 0436 hrs Jan 3, 2009 Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 🗸 Suicide Could not be or Town, State) 1332 Hollow Glen Court, Orchard Beach, MD determined (Specify) Hanging from tree in yard Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

To the Fineral Director:

29b. Signature and title of certifie 30. Name and address of person who complete (cause of death (Item 23a) Assistant Medical Examiner Theodore M. King, Jr., MD.

29d. Date signed (Month, Day, Year) 29c. License number January 4, 2009 O.C.M.E. OCME

111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) State Registra

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2009 Year Physician William Henry Brown, Jr. Jan. 2:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 600 Straffen Dr. Apt. 504 Timonium Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1∏ M 2□ F Months Days Hours Min. Director 213-28-0756 81 July 10 1927 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 Is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner minet be a show once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 600 Straffen Dr. Apt. 21093 504 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo white þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Commercial Real Estate Consultant Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Henry Brown, Sr. Mary Elizabeth Long 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bettye June Brown/wife 600 Straffen Dr., Apt. 504, Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buria! 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Atlantic Crematory 1/11/09 Glen Burnie, MD 21. Signal are of Fun rel privice Licensee 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Michael J. Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** YOCARD AL +cuts 1-640 /Medical Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) physician as the burial P.O. Box 68760. as esn. IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 4☐Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) 2 No 1 Yes Other: 4 Nursing Home 1 Inpatient P 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) 27. Manner of eath 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident (Month, Day Year, Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b./Signaturela title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

32. Registrar's Signature

Denne

BZIAN

SONAL

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

-E 4940 32. Registrar's Signature

To Be Completed by Funeral Director

Physician

/Medical

Examiner

Funeral

Director

/Medical

	Type or Prin State of Ma						_			
For State Registrar		•	•	ate of			•	Reg. No.	20	
. Decedent's Name <i>(First, Middle, La</i> DONALD LEE BLUBAU	•						2. Date of D Month	Day		Year 0440 A-M
a. Facility Name (If not institution, giv			4b. 0	City, Town, o	r Location of	Death	JAWA	_	County of	4 1 0 .
Johns HOPKINS BA		CAL CENTER		-	BALTIN					ORE CITY
219-04-8881	Sex M 2□ F 52	(In yrs. last birthd	Mon	nder 1 Year ths Days	If Under 24 Hours	4 Hrs. Min.	8. Date of B (Month, D APR.	Ith 16, 1	956	9. Birthplace (State or Foreign Country) MARYLAND
a. State 10b. County		10c. City, Town or	r Location							10d. Inside City Limits
ARYLAND BALTIMOR	E COUNTY	DUNDA	LK							1 □Yes 2 🕅 No
e. Street and Number			10f	. Zip Code				10g. Citi	zen of Wh	nat Country?
MAVISTA AVE.				21222						STATES
Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Tyes 2 XN If Yes, Give Year or Dates:		If Yes,	ecedent of H specify Cub s 2 No	lispanic Origi an, Mexican, Specify:	in? (Sp Puerto	ecify Yes or N Rican, etc.)	0-	Black,	- American Indian, , White, etc. WHITE
15. Decedent's E	ducation	16a. De	ecedent's	Usual Occup	ation	-6		16b. Ki		iness/Industry
(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	+) lif	fe. DO NO	OT use retire	during most o d)	or work	ing			D. W. J. W. T. O. J.
II		TRUC	CK DR	RIVER	10 Mathari	o Nome	e (First, Middl			RTATION
. Father's Name (First, Middle, Last ARRY C. BLUBAUGH							R. WII		ourname,	,
a. Informant's Name/Relationship		19b. M	lailing Add	ress (Street					r Town, S	State, Zip Code)
ERN BLUBAUGH/ WI	FE	9 M	AVIST	A AVE	., DUN	DALI	K, MARY	LAND	2122	22
a. Method of Disposition	1B	20b. Place of Di cemetery,	sposition crematory	(Name of or other pla	ce) T/	AN.	Date O	20c. Lo	cation - C	City or Town, State
1 ABurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		GLEN HA	AVEN	MEM. I		200		GLE	N BUF	RNIE, MARYLAND
. Signature of Francial Solving Lice	ee		KIRK 421	e and Addre LEY-R CRAIN	DDICK HWY.,	FUI S.	NERAL H	IOME EN BÛ	P.A. RNIE	, MD 21061
3a. Part 1. Enter the disease, or com shock, or heart failure. List only			enter the	mode of dyi	ng, such as c	ardiac	or respiratory	arrest,		Approximate Interval Between
nmediate Cause (Final sease or condition	_a. Se	EPSIS								Onset and Death
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equentially list conditions,	υ.	a consequence of):		>		_				2 WELS
any, leading to immediate	_									
at initiated events sulting in death) Last	Due to (or as	a consequence of):								
	d									
FEMALE: 8b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		pic pregnander (specify) _	су				23d. Date Mont	of delivery th Day Year
art II. Other significant conditions	contributing to death be	ut not resulting in th	ie underlvi	ina cause aiv	en in Part I.		23e. Did	tobacco u	ıse contrit	bute to the cause of death?
INNACRI		temorza		_	on my aren.			Yes 2		3 Probably 4 ☐ Unknown
							24a. Wa	e an	24h W	ere autopsy findings available
MYCANDIA	L INCEPT.	LETION_			· · · · · · · · · · · · · · · · · · ·		aut per 1 □ Yes	opsy formed? 2 No	pr de	ior to completion of cause of eath? Yes 2 \(\sum \text{No} \)
5. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 🗆 ER/Outpa	ntions 2 F	Oth	or.		h (Check only		0 704	- 40 - 14)
7. Manner of Death 1. Natural 5 □ Pending 2. □ Accident investigation	28a. Date of Inju (Month, Day	ry 28b. Tim	ne of	28c. Inju Woi	ry at		ome 5 ☐ Re 28d. Describe			
3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injubulding, etc	ry - At home, farm, c. (Specify)	, street, fa	ctory, office			28f. Location City or To	(Street an own, State	d Numbei)	r or Rural Route Number,
9a. Certifier 1 ✓ ertifying P (Check only one) 2 ☐ Medical Exa	hysician: To the best of miner: On the basis of and manner sta	f examination and/o	leath occu or investig	irred at the t ation, in my	ime, date and opinion, death	f place, h occur	, and due to the	e cause(s e, date and) and mar I place, ar	nner as stated. nd due to the cause(s)
9b. Signature and title of certifier	<i>a</i> .			29c. Licens						(Month, Day, Year)
1 man	The o	70		RE	5-00	0		51	TNVA	my 5 2009

State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 1/2001

EASTERN

AUENUE

BA-TI MONE 118 21224

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Bendler January 2009 Theodore Harry 3:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Timonium Stella Maris Hospice Ctr. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 1,1924 9. Birthplace (State or Foreign 5. Social Security Number Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Funeral Days Maryland 84 217-12-8339 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Machael Evanter must be notified at once. Dundalk Baltimore 1 ☐ Yes 2 🖾 No Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 United States 3002 Dunmore Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2K Married WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry Bricklayer 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)

James M. Bendler Be Ida Doulong မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3002 Dunmore Road Dundalk, Maryland Mrs. Dolores Bendler (Wife) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Hilltop Service Corp. 1/8/09 Towson, Maryland 4☐ Donation 5 ☐ Other (Specify) Funeral Service Licen Buda-Ruck Funeral Home of Dundalk, 21222 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiral by arri List only one cause on each line. Approximate Interval Between erval De... nset and Death Immediate Cause (Final Physician Su disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Vital Records, P.O. Box 68760, Physician/Medical cate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 🗆 No spital or Attending Physician: The hours after death.
Ineral Director: After this certificate y filled in by the funeral director, pa 1 ☐ Yes 2 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) aminer? Other: 4 \(\sum \) Nursing Home examiner: 1 Yes 2 □ No 5 ☐ Residence 6 XOther (Specify) HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To o 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? Injury 5 Pending investigation 1 Natural KWKNOWNM 1 ☐ Yes 2 No 15 8005 DOWN 8 2 Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide DUNMOR AT HOME 2000 within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Datę signęd (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5+1 JACKIE_JONES, 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 CRNP 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 8 2009 Registrar

2009

ANUARY

THEODORE BENDLER

Division of Vital Records, P.O. Box 68760, 多

			1 - State Registrar					Cer	tifica	te of L	Death	1		Reg. N	lo. 20	09	_0	019
	Physici /Medic		1, Decedent's Name	KENN	EIH W.		UTTERM	ORE					2. Date of Month Janua	ry (8, <u>200</u>	99 ar	3. Yim	238 M
	Examir	er	4a. Facility Name (# 2900 Crys			number)				Pasao						ne Arui		
	Funeral Director		5. Social Security Nu 178–34–938 th Usual Residence of	5	6. Sex 1 M M 2 □ F	7. Age (6	in yrs. last	birthday) . Yrs.	If Unde Months	Days	If Under Hours	Min.	8. Date of (Month			9. Birthpl Coun Pennsy		ia ia
	Maryland a-f show	ctor	10a. State Maryland	10b. County	e Arundel	11	0c. City, To	own or Loc Pasad								10		le City Limits Yes 2 M No
	with the	Dire	10e. Street and Num 2900 Crys		ace Lane				10f. Z	p Code 21	122			10g. 0	Citizen of W		try?	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Mydical Evarritha i sust by notified at	by Funeral Director	11. Marital Status 1 Never Marrie 3 Widowed			Forces? 3 2 M No Give	er in U.S.			edent of H ecify Cuba 2 No	ispanic Oi In, Mexica Specify		ecify Yes o Rican, etc.	No-	14. Race	e - Americ k, White, e	tc.	n,
Baltimore, Maryland 21215-0036	ithin 72 hou ne. han "natural	Completed		15. Decedent fy only highes	's Education at grade completed		1	life. L	kind of w	ork done d use retired	during mos	st of worki	ing		Kind of Bu Itional		-	Agency
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Mary	nd 2 shou alth and № 27 is ma er trauma		19a. Informant's Na Harriet A		nip <i>(Type. Print)</i> rmore (Wife	e)			_				a <i>i Route Ni</i> Pasaden	-		-	Code)	
more,	permit. Pages 1 and 2:3 Department of Health a Important: If item 27 is any injury or other trau once.		20a. Method of Disp 1 Ø Burial 2 ☐ 4 ☐ Donation	Cremation	3 □Removal from	m State	20b. Place ceme	e of Dispose etery, cremeter ette M	sition (Na natory or em. P	me of other plac ark	e) (01-12-	Oate 09		Location -			
Balti	permit. I Departm Importa any inju		21. Signature of Fo			118:11	//	Mg	Name a	nd Addre	ss of Facil	ity uneral	Home dena.	P.A.	nd 211	22		
	Physician /Medical	0	23a Part 1. Enter the shock, or hear Immediate Cause (I disease or condition resulting in death)	t failure. List Final	complications that only one cause or	each line.	rios	Do not ente	er the mo	de of dyir	ig, such a	s cardiac		ry arrest,		,	Approxi Interval Onset a	imate Between and Death
68760,3	certificate be executed by triple in the burial-transit by	ical Examiner	Sequentially list con if any, leading to imr cause. Enter Under Cause (Disease or i that initiated events resulting in death) L		b Due t	o (or as a c	consequen	ce of):										
O. Bo		Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 i 1 □ Yes 2	nonths?		e birth 2 (egnant at tir	☐ Fetal de	eath 3	Ectopic Other (s	pregnanc specify) _	у	•	**************************************		23d. Dat Mo	e of delive	ery Day	Year
rds, P.	w requires that the death s been signed by the atter should be detached for u		Part II. Other signifi	cant condition	ons contributing to	death but r	not resultin	ng in the ur	nderlying	cause giv	en in Part	I.			o use contr			of death?
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Vita	yslclan: The is certificate director, pag	Be	25. Was case referrence examiner? 1 Yes 2 □ I		Hospital*	□Inpatient	2□ER	l/Outpatien	it 3 🗆 🗆	Oth			me 5		6 □Othe	er (Specifi	v)	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification: To	27. Manner of Death 1 Alatural 2 Accident	5 ☐ Pendin investig	g (Me	te of Injury o <i>nth, Day</i> , Y		Bb. Time of Injury	М	28c. Injur Worl	y at		28d. Descr					
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certific	3 ☐ Suicide 4 ☐ Homicide	6 Could i	: ZOU, FIA	ce of Injury Iding, etc. (r - At home (<i>Spe</i> c <i>ify</i>)	e, farm, stre	eet, facto	ry, office			28f. Locatio City or	on (Street Town, Sta	and Numbe ate)	er or Rura	l Route i	Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one)		ng Physician: To t Examiner: On the and ma		xamination											se(s)
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_	10		Willin	m f	who completed ca	25,	m	D	Print)	5	A	me	rici	4	21	03	5	
	Sta Regist		31. Date filed (Mont	h,-Day, Year) 8 2009	Beneva	Registrar's	s Signature	arted	•								-	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 00197

Physicia									1'0 D.1(D.	-41-		3. Time of Death
dical Examin	er	eqistrar Decedent's Name (First, Midd ROBERT L. BET		2. Date of De Month January	1, ^{Day}	Year	1444 hrs					
	4	 Facility Name (if not institution Johns Hopkins Hospi 		and number)		4b. City, To Baltim		cation of Dea			inty of Dea	- 0
Funeral Director	5	Social Security Number	6. Sex	, , ,	. last birthday)	If Under Months		If Under 24H Hours M	lin.		Fore	Birthplace (State or eign Country) FLORIDA
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Maryland 28a-f show any d at once.		0a. State 10b. County MD • N/A	7		BALTIMO:							1 X Yes 2 No
Marylar r 28a-f s	Director	De. Street and Number		TAGE DD		10f. Zip	Code 1221		1 5 7	10g. Citizen		ountry?
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한 등 팀	<u>a</u>	3 Widowed 4 X Di 15. Decedent's Education (Sp	vorced or Da	Give Year	1 16a Decede	Yes 2	Occupation	n (Give kind o	of work done		of Busines	ACK ss/Industry
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21215-0036 and be filed within 7 Mental Hygiene marked other than ic event, the Medica	å	ROBERT L. BE	THEL,			- 2 - 2 - 3 - 1 - 2		VERNE	LL MOSL	EY		late Zin Code)
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re, MD s 1 and 2 sho of Health and If item 27 is ner traumati	1	20a Method of Disposition	-	20	b. Place of Disp	osition (Nar	ne of ceme		Date	20c. Loc	ation - City	or Town, State
F 8 7 7 2 8		A / _/		emoval from State	crematory or SUNSET M	EMORI	AL					RDALE, FL.
Baltimore, permit Pages 1 a Department of He Important: If ite		4 Donation 5 Other 21. Sent for of Funeral Service	e Lic (se)		HIBN-A	Name and	Address o	of Facility R	OY MIZE FT. LA	LL & KU UDERDAI	JRTZ LE, F	FUNERAL HOME LORIDA 33311
Physician		23a. Part . Enter the disease, fell are. List only one caus	or complications on each line	ns that caused the de	eath. Do not ente	r the mode	of dying, s	uch as cardia	ac or respiratory	arrest, shock	or heart	Approximate Interval Between Onset and Death
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760, cate be execut physician and	edical	UNPENDED		sc. If yes, outcome of p	oregnancy	_				23d. I	Date of del	livery
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Division of Vital Records, tal or Attending Physician: The law requir as after death. "In Director. After this certificate has been s' led in by the funeral director, page 2 should I	Certification:	3 Suicide 6 O	ould not be etermined	28e. Place of Injury -		street, facto	ry, office b	uilding, etc.	or To	tion (Street an wn, State) Fayette Stree		or Rural Route Number, City ore, MD
Hospi 24 hou Funer tely fil		4 Homicide		To the best of my kno	udodao death o	ccurred at th	he time, da ny opinion	ate and place	and due to the	cause(s) and	manner as	s stated.
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		On me		ww			O.C.	M.E.		Janu	ary 2, 2	
ELL		30. Name and address of per Donna M. Vincenti,		pleted cause of death sistant Medical E		111 Penr	n Street	, Baltimor	e, MD 2120	1		
5+1	State	31. Date filed (Month, Day, Ye		32. Registrar's Si		barks				-		

		Ple	ase Type or Prin							_	
		1 - For State Registrar	State of Ma	aryland / l		rtment of F	lealth and N Death		Reg. No.	2009	00198
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Funera Directo	-	5. Social Security Number 220–30–5787		je (In yrs. last bii 94	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)	Co	hplace (State or Foreign untry)
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with the	Director	10e. Street and Number 7920 SCOTTS L	EVEL ROAD			10f. Zip Code	21208		10g. Citi	zen of What Cor USA	untry?
after death w	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. W	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No Rican, etc.)		14. Race - Ame	
urs	þ	1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	If Yes Give A	No		□Yes 2∏No	Specify:			Specify: WH	ITE
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t. Pa rtmer rtant	aŭ	4 □ Donation 5 □ Other	(Specify)	BALTIN		HEBREW Name and Addre		7/2009 L LEVIN		STERSTO	
Department of the second of th	9000	21. Signature di Fulleral Service	> ?	1			ERSTOWN R			ILLE, M	
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rtificate ng phys as the	Medic	IF FEMALE:	d								
The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		e of pregnancy 2 Fetal death at time of death		Ectopic pregnand Other (specify) _	ey			23d. Date of del Month	ivery Day Year
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slcian: The certificate rector, pag	Be Co	25. Was case referred to medic	al				26. Place of Dea	1 □Yes th (Check only o		1 □ Yes	2 No
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tal or At s after d al Direct ed in by	Certifi		mined 28e. Place of In	jury - At home, fa tc. <i>(Specify)</i>	arm, stre	eet, factory, office		28f. Location (: City or To			ıral Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, is	Medical		ying Physician: To the best al Examiner: On the basis and manner s	of examination a							
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DHMH 17 Rev 1/2001

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The State of the Country State	Examine Funeral	er	5. Social Security Number 216–68–7348	6. Sex 7.	Age (In yrs. last I	birthday) If Un	ALTIM der 1 Year	Under 24 Hrs.	7 / 8 Date of Bi (Month, Di 11/20/	tth ay, Year)	9. Bit	ath rthplace (State or Fo
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The state of the		eral				13 Was De		anic Origin? (Spe	cify Yes or No			erican Indian
Tather's Name (First, Marine, Installant Sumanna) George R. Wiley 19a. Informant Name Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State. Zip Code) 3307 Sssex Road, Baltimore, Maryland 21207 21. Some of Committee of Disposition 1. Donator S. Donator		2	1 ☐ Never Married 2 ☐ Marri	Armed Force 1 Tes 2 If Yes, Give	es:	If Yes, s	specify Cuban,	Mexican, Puerto F	Ricán, etc.)		Specify:	Black
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State of Maryland / Department of Health and Mental Hygiene 00200 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 4, January 2009 Phyllis Linda Anderson Chase 12:30A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Seasons Hospice & Palliative Care Baltimore Randallstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months Days 1 □ M 2 🛣 F Hours Yrs. 219-64-9985 57 Director March 16, 1951 Canada Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, In Medical Events. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Director Baltimore Phoenix Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14311 Phoenix Road 21131 Canada Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: Š Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William James Anderson Phyllis Booth ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Judith M. Anderson/sister 1169 Bay Ridge Road Annapolis, Maryland 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory 1/8/2009 Odenton, Maryland 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. 21. Signature of Funeral Service Lipensee uanita R France Odenton, Maryland 21113 1411 Annapolis Road 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration pneumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): End-stage multiple Sclenosis Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mannumf Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0057465 apatheme suite 200, Reisterstown, MD. 21136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 Kajapakse MD 25 Mainst.

Registrar

State

31. Date filed (Month, Day, Year)

JAN 08 2009

Box 68760

P.0.

32. Registrar's signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 00201 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year 9:49 Q.M Carl E. Cookerly 2009 /Medical Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death Examiner Health Care N/A Age (In yrs. last birthday) 8. Date of Birth

Jan. 1930 II Under 1 Year Social Security Number Birthplace (State or Foreign **Funeral** Days Hours Months Maryland 215-28-6561 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 28a-f show MD Baltimore 1 ☐ Yes No Lansdowne Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4230 Hollins Fry Rd., Apt. 108 21227 <u>United States</u> Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No 1950 – If Yes, Give Year or Dates: 1954 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Personel Supervisor Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jesse Carlton Cookerly Charlotte Amelia Manke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeannie Marsh 14801 Bell Street, Cumberland, MD 21502 Method of Disposition

1X Bunal 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Good Shepherd Cemetery 5 Other (Specify) 1-10-2009 Ellicott City, MD 4 Doration 22. Name and Address of Facility Ambrose Funeral Home, Inc. uneral Service License 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dreumonia Physician unknown /Medical Due to (or a a consequence of) Examiner-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Attending Physlclan: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Completed by Physician/Medical f yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funera (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 Caton Avenue

Registrar's Signature

alck

31. Date filed (Month, Day, Year)

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Baltimore, Marylan

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #2 Per DVR G8871/08/09 JH
State of Maryland / Department of Health and Mental Hygiene 00202 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009ear Month **Physician** 11:15 a^M ANNIE D. CARWELL January 1009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE 4001 CLARKS LN APT 516 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2XX Yrs. 58 Director 15 1950 MARYLAND 217-56-5870 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event. The Medical Evan mentions to motified at 1 X Yes 2 □ No Director BALTIMORE MARYLAND N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 U.S.A. 4001 CLARKS LN **APT 516** Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo Maryland 21215-0036 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates Specify. Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CARE ASST.) (DIRECT ROSEWOOD HOSPITAL 12 should be filed w th and Mental Hygien 7 Is marked other th 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (RUFUS CARWELL MARY E. CARWELL ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) t: If item 27 Is Pages 1 and 2 117 Caraway RD., Reisterstown, Md., 21136 Rudy Clifton/Son Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page:
Department o
Important: If i
any Injury or
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MT CALVARY CEMETERY 01-10-09 GLEN BURNIE, MARYLAND 4 Donation 5 Dother (Specify) 21. Signature of Fund Saying Manager 22. Name and Address of Facility Masie WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** H-00%. 12061 disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if my lead of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. attending physiciar Completed by Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy ō Month Day Year 5 Other (specify) ned by the a detached for P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, sign be 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 📈 No 1 □Yes 2 2 No 1 🗌 Yes After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending investigation ours after death.

neral Director: Air 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) west Balve Jene

Registrar DHMH 17 Rev 1/2001

State

5 MD 2435 32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** CAMPBELL AGNEC 615 PM 01 05 ,2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE NU RSING MOME ALICE MANDE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□ M 2□F 217-64-6679 78 9-19-1930 Director Maryland Usual Residence of Decedent with a should be filled within 72 hours after death with the Maryland valth and Mental Hygiene.

27 is marked other than "natural" or the straumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A 1 Yes 2 No Maryland Director Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2095 Rockrose Avenue 21211 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes XX No If Yes, Give Year or Dates: MXNever Married 2 ☐ Married 1 ☐ Yes 2 🗷 🗙 No Baltimore, Maryland 21215-0036 Specify. ģ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) N/A N/A Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be Leo Thomas Campbell Irene Catherine Booze 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Campbell 3366 Alden Place NE Washington, DC Brother 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 2 ☐Cremation 3 ☐Removal from State Burial Oak Lawn Cemetery 5 Other 1/13/2009 Baltimore, Maryland of Funer 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc 3631 Falls Road Baltimore, Maryland 21211 Part1. Enter the diseas shock, or hear ailure. sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner necho 101 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of) Examiner certificate be executed Imaema and Due to (or as a consequence of): P.O. Box 68760, physician Diabele Physician/Medical the the attending property of as IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ğ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? certificate 1∐ Yes 2∐No 1 ☐ Yes 2 ☐ No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospitan control within 24 hours after death.

To the Funeral Director: After this control with the funeral director is the funeral director. 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA this 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. ENTANST Soute HAPHMI 314 BALTIMOREMIN 21201 A 31. Date filed (Month, Day, Year) 3 Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

State Registrar 30. Name and address of person who

31. Date filed (Month, Day, Year) JAN 08 2009

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npleted cause of death (Item 23a) Type, Print)

2. Registrar's Signature

Reg. No. State of Maryland / Department of Health and Mental Hygiene, 00205 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year :5/ P.M **Physician** Richard Davis Dean 2009 anvary /Medical 4c. County of Death Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 3 JA(N/A -NES HOSPITAL Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Min. 1 ☑ M 2 ☐ F 84 Yrs. 30. 1924 West Virginia 219-14-5311 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Modest Examination rulat be notified at 1 ☐ Yes 2 YNo **Funeral Director** Catonsville Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 USA 311 Montrose Avenue Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1942 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ∐Yes 21又No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 1945 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) College Professor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Amelia Houghton Frederick Merten Dean ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 311 Montrose Avenue Catonsville, Maryland 21228 Eleanor Dean, Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State ō permit. Pages
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Important: If i
any injury or
once. Metro Crematory Inc. 01/07/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Usensee
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Arterioselectic Vasular **Physician** 10 Known a. Coronary disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dee to for as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): the attending physician hed for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) detached 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2. No 1 ☐ Yes 2 Ø No 1 TYes Division of Vital : After this certifica e funeral director, p Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 🗌 Inpatient Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 6, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Moryland St Agner Itomita 900 Caton 32. Registrar's Signature State Registrar

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		For State	State of Ma	aryland / I	Jepartment <i>Certificate</i>		and Mental Hy	glene Reg. No. 200	9 00206
		Registrar Decedent's Name (First, Middle,	Last)				2. Date of De	ath	3. Time of Death
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, Examin		4a. Facility Name (If not institution,	-	1.10	4b. City, To	own, or Location		4c. County of De	eath N/A
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72 hours after death with the Maryland 'ratural', or items 23a or 28a-f show dical Examinate hamoffind at	þ	₩Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □ Yes 2	No Specify.		Specify:	WHITE
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nd 2 sh Ith and 27 Is n traun		19a. Informant's Name/Relationsh JOANNE RADFOR					er or Rural Route Numb		
s 1 an of Hea item ?		20a. Method of Disposition			of Disposition (Name		Date	20c. Location - City	·
Page ment ant: If		1 X Burial 2 ☐ Cremation 3 ☐ Other (Sp					US 1/9/09	BALTIMO	RE, MARYLAND
permit. Pages 1 and 2. Should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		21. Signature of Funeral Service L	icensee	1	22 Name and	Address of Facili	ER INC. F	UNERAL H	OME 21221
	\dashv	23a. Part 1. Enter the disease, or o shock, or heart failure. List of	complications that caused	the death. Do			AVENUE, B		Approximate
Physician		shock, or heart failure. List of Immediate Cause (Final disease or condition	only one cause on each li	ne. Naara	rd. I	in fur	Lion		Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):	1 L	tion Failures	,	
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	_	resulting in death) Last		a consequence	of):				
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n certif ending use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				23d. Date of	delivery
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sician certifi irector	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpati	× FR/0	utpatient 3 DOA	Other:	e of Death (Check only		
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tendin eath. or: Af the fur	catio	1 Matural 5 ☐ Pending 2 ☐ Accident investigs 3 ☐ Suicide 6 ☐ Could n	ation		M	1 □Yes 2 □			
lor At after d Direct	Certification: To	4 Homicide determine	28e. Place of In	ury - At home, to c. <i>(Specify)</i>	arm, street, factory,	office	City or To	Street and Number or wn, State)	Rural Route Number,
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page			Physician: To the best						
the Ho hin 24 the Fu	Medical	one)	examiner: On the basis of and manner st				ath occurred at the time.		
co vit		29b. Signature and title of certifier	Fille V	127	290.	License number	298	29d. Date signed (Mo	n Ca
10		30. Name and address of person v	who completed cause of	death (Item 23a)	(Type, Print)	, ,,,	~ 0	2110210	,-1
1		Drew Fuller, M	D Johns H	opkins	Bayview	4940	Eastun A	oe Dalli	an MDZ122
Sta Registra		31. Date filed (Month, Day, Year) JAN () 8 20		ral s Signature	1				
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 07:52M an 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 90001 Carroll County General Hospital Westminster 8. Date of Birth (Month) Day If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Year) Months Days Hours Min Mary land M 2□ F 218-02-5133 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Sykesville 1 □Yes Ž∏No MD Carroll Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21784 USA 7307 Gaither Road by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2**X** No Specify: 3 Widowed 4 Divorced Specify: White Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lillian L. Willhide Arnold William Evens, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7307 Gaither Road, Sykesville, MD 21784 19a. Informant's Name/Relationship (Type. Print) Vivan Keyser - sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 01/07/2009 5 ☐ Other (Specify) Baltimore, MD 4 □ Donation 21. Signature of Funeral Streven FII. Williams ²²Cremation Society of Maryland, Inc 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** hours disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the hural Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ed by the a detached f 9 Unknown as been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Nes 2 No 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? nis certificate has t director, page 2 s 2 🗆 No 1 □ Yes 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 3 DOA 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient After this Medical Certification: To nours after death.

neral Director: After this

filled in by the funeral di 27. Mapper of Death
12. Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signatui and title of c Jan 6, 2009 Patrixed Pkwy

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) // 0.5.5

M1)

32. Registrar's Signature

J ACK

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Ellison homas 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Jolumbia HOSDHal Howard COUNT Birthplace (State or Foreign Country)
 SC If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9–15–1932 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Hours Min. 1√2 M 2□ F 76 124-24-9181 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1√ Yes 2 No Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21215 5430 Park Heights Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black 1 □ Yes 2 🛣 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Gospel Singer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Tda Mckie Ausbon Ellison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1605 Braid Hills Drive. Pasadena, MD 21122 Gloria Shelton - Neice 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Smyrna Bapt. Ch. Cemetery 1-11-2009 Springfield, S.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a sequence of): disease or condition resulting in death) Candida Sep Due to (or as a consequence of) Kespivatovi Due to (or as a consequence of): 5

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed by

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division or Vital Records,

Attending Physician:

death.

certificate be executed and use as the burial-trar

signed by the attending physician d be detached for use as the buria certificate funeral director, this After

Examiner Physician/Medical þ Completed Be P Certification: To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Onknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 No OPD 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 TYes 2 No 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

gause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Behen

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00209 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2009 Ja'n 6, Robert Lee Ensor 2:39 AM M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carrol1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Days Months Hours Min. 1/19/1932^{ear)} Maryland 213-30-7085 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Carroll Sykesville 1 ☐ Yes 2XXNo 10g. Citizen of What Country? United States 10e. Street and Number 7505 Woodbine Rd. 10f. Zip Code 21797 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 Tho 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced White 1 ☐ Yes ŽINo If Yes, Give Year or Dates: Specify: Specify 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George F Ensor Emma G. Eppers 19a. Informant's Name/Relationship (Type. Print) Charles O. Ensor 19b. Majling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3144 Gracefield Rd. Apt 101 Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place)
S. Carroll Crematory 20c. Location - City or Town, State Date 3 Removal from State 1/8/2009 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature Burrier-Queen Funeral Home and Crematory, P.A. 212 W. Old Libert Rd. Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MEDIMONIA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 1No 1 Yes 2 →No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 217No 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

MD Director

Funeral

Completed by

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lujury or other traumatic event, the Modical Evarainer must be notified at anone.

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

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Physician/Medical Examiner Completed by Be Certification: To

within 24 hours after death.

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State

Medical

31. Date filed (Month, Day, Year)

25. Was case referred to medical examiner? 1 ☐ Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and mariner stated 29b. Signature and title of certifie

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29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

102 54178 Registrar's Signature

Registrar

09-00156 David Falkinburg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 00210

		1- For State Registrar		tificate of	Death		Reg	2 U U	9 0021
Physicia edical Exami	an/	1. Decedent's Name (First, Middle, La David Falkinbu	ırg				January 6,	Day Year 2009	3. Time of Death 1030 hrs
		4a. Facility Name (if not institution, g 2812 Clearview Avenue	ve street and number)	4	b. City, Town, c Baltimore	r Location of Death	***	4c. County of Death N/A	
Funeral Director		140- 104-64-7468	Sex 7. Age (In yrs. la	ast birthday) 45 Yrs.	If Under 1 Ye Months Da		8. Date of Birth	(MM/DD/YYYY) 9. Bir 21,1963 Co	thplace (State or New Jersey untry)
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after de al", or i	by Fu	3 Widowed 4 Divorce	1 Yes 2 X No lif Yes, Give Year or Dates:	1	Yes 2X N	o specify:		Specify: Whi	te
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5-0036 iled within 72 Hygiene. Jother than "	Completed	12		Was	iter			Restau	rant
21215-(uld be filed by Mental Hygen marked oth tevent, the	Be Co	17. Father's Name (First, Middle, Las Bobby Gene Conne				18.Mother's Name Nancy	e (First, Middle, M Scan 7 M. Scar	aiden Surname) napieco Mapiego	
O et a si	2	19a. Informant's Name/Relationship Nancy M. Conner,		_		eet and Number or	Rural Route Numb	per, City or Town, State	
imore, MD 2 Pages I and 2 shou ment of Health and I lant; If item 27 is no other traumatic		20a. Method of Disposition	20b. F	Place of Disposi	ition (Name of c		Date	20c. Location - City or	
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Balt permit Depart Impor	Ц	21. Signature of Funeral Service Lice Thomas Gregor	insee	_ ²² C	remation 99 Fred	ss officility n Society erick Roa	of Mary	land, Inc. more, Maryl	and 21228
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	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence o	f):					
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760, icate be executed physician and the burial - trans	/Medical	UNPENDED IF FEMALE:	X AMENDED #5, 18,		. 0007 1			23d. Date of deliver	y
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Vital hysician: this certif	To Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	ER/Outpatient		Othor		Residence 6 🗸 Othe	r: Scene
	on: 1	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) Jan 2, 2009	28b. Time of I 1445 hrs		jury at Work? Yes 2 ✔ No	28d. Describe h Subject stab	ow injury occurred bed and cut	
Division pital or Attendi ours after death teral Director: /	Certification:	2 Accident Investiga 3 Suicide 6 Could no	ation 28e. Place of Injury - At he	ome, farm, stree			28f. Location (S or Town, St		ural Route Number, City
Divis lospital or A thours after uneral Dire		4 Homicide determine 29a. Certifier 1 Certifying Physics	led (Specify) Single Fan		red at the time	date and place, an	2812 Clearviev	w Avenue, Baltimore	
To the Hospital within 24 hours. To the Funeral completely filled	Medical	one) 2 Medical Examin	er:On the basis of examination a and manner stated.	ind/or investigat	ion, in my opini	on, death occurred	at the time, date a	and place, and due to ti	ne cause(s)
	Σ	29b. Signature and title of certifier	1,415			nse number C.M.E.		29d. Date signed (Mo	
h		30. Name and address of person wh	o completed cause of death (Item						
	ate	Donna M. Vincenti, MD 31. Date filed (Month, Day, Year)	Assistant Medical Exan	100		et, Baltimore, N	/ID 21201		
Regis	trar	31. Date filed (Month, Day, Year)	Brown A.	parke					

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Physician Medical Examiner Manufacture	Marylan -f show	tor		10c. City, Town or Lo	ecation	Midd1	e River				
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To a manufacture of the second	n 24 house n 24 hou ne Funei pletely fil	edical	(Check only 2 Medical Examiner: On the basis of	examination and/or in							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Padgett MD, 5601 Loch Raven Blub, Baltimore, MD 21239 State 31. Date filed (Month, Pay, Year) 32. Registrar's Signature Backstrar A Registrar's Signature	To the within company	Ž	29b. Signature and title of certifier Cuar Vordage H N	Cu	Dir			TOOM	n, Day, Year)		
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)	/Medic Examin		4a, Facility Name (If PLEAS AM	UNAT	ve street and number) NuRSING 10NAL PL Sex 7. Ag	Hom KE e (In yrs. las		MOUNT	T ALRY		40	County of Dea	th	
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UU36 hours after death with the Maryland	pene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	233 HOC 11. Marital Status 1 Never Marrie 3 Widowed	ed 2 Married	12. Was Decedent Armed Forces? 1 X Yes 2 1 If Yes, Give Year or Dates:	No		211 B. Was Decedent of If Yes, specify Cub 1 Yes 2 XNo	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No Rican, etc.)		SA 14. Race - Ame Black, Whit		
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Datt	Important: any injury		21. Signature of F	neral Service Lic	ensee			22. Name and Address 254 E. M.		ETCHER	FU	NERAL	HOME, P.A. MD 21157	
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58 / 50, tificate be exec	attending physician and for use as the burial-transit	_	resulting in death) L	ast	Due to (or as	as a consequence of):								
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rdS, P.	gned be de	by	-		contributing to death b	ut not resulti	ing in the	underlying cause gi	ven in Part I.			tobacco use contribute to the cause of death? Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown		
	certificate has been si irector, page 2 should I	Completed	CARCINOMA & PROSTATE					24a. Was auto per 1 Yes	s an opsy formed? 2 N	prior to death?	utopsy findings available completion of cause of			
Or Vital Physician:	s certifica director, I	To Be	25. Was case referrexaminer?	/	Hospital:	ent 2 EF	R/Outpati	ent 3 DOA Oti	26. Place of Dea			6 □Other (Spe	ecify)	
On O	th. : After this e funeral di		27. Manper of Death 1 Natural 2 Accident	n 5 ☐ Pending investigati	28a. Date of Inju (Month, Da	y Year) 2	8b. Time Injury	/ Wo		28d. Describe			,,	
DIVISION OF Hospital or Attending Phy	after death. I Director: / d in by the f	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	28e. Place of injuding, et	ury - At hom c. (Specify)	e, farm, s	street, factory, office		28f. Location City or To			ural Route Number,	
e Hospita	within 24 hours after d To the Funeral Direc completely filled in by	Medical C	29a. Certifier (Check only one)	1 M Certifying F 2 Medical Ex	Physician: To the best aminer: On the basis o and manner sta	f examinatio	edge, de on and/or	ath occurred at the t investigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time	e cause(s	s) and manner a nd place, and du	s stated. e to the cause(s)	
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4	140		Name and address N. B. VELL	ess of person wh	s completed cause of d	eath (Item 2	(Type	e, Print) ARKUT	1y 4 308	Colu	ום חמ	a, mo-	21045	
	Sta Registr		31. Date filed (Mont	th, Day, Year)	32. Registr	ar's Signatul	te food	which						
DHMH	17 Rev 1/2		AL.	MIRKO	UJ AARTON	1	1/							

		Please 1 - State Registrar	Type or Print i State of Mary	land / Depa		Health and I	Mental Hy			00213	
Physicia		1. Decedent's Name (First, Middle, La	arrett				2. Date of Dea Month	ath Day	Year	3. Time of Death	
/Medic Examin		4a. Facility Name (If not institution, gi			or Location of Death	January		2009 ounty of Death	_2052		
Funeral Director		5. Social Security Number 215-30-6177 Usual Residence of Decedent	yrs. last birthday) Yrs.	If Under 1 Yea	If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Bir (Month, Day, Year) 9. Bir (Month, Day, Year) 04/10/1933 March						
aryland show	ŗ	10a. State 10b. County	100	c. City, Town or Lo		1	0d. Inside City Limits 1X Yes 2 □ No				
r 28a-f show	Director	Maryland 10e. Street and Number		Balt	10f. Zip Code			10g. Citize	n of What Coun		
th with 23a or	al Di	3215 Spaulding A	venue			21215		U.S	5.A.		
.0	by Funeral I	11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1YesXNo If Yes, Give Year or Dates:	I	Was Decedent of fYes, specify Cu I □Yes 2 🏋 N	f Hispanic Origin? (S aban, Mexican, Puert o <i>Specify:</i>	pecify Yes or No- o Rican, etc.)		. Race - Americ Black, White, e pecify: Blac	etc.	
2 should be filed within 72 hours and Mental Hygiene. is marked other than "natural", raumatic event, It's Medical Exa	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. Deced (Give life. L	dent's Usual Occ kind of work don OO NOT use reti	upation le during most of wor red)	king	16b. Kind of Business/Industry Cleaners			
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, If a Moce.	Be Cor	17. Father's Name (First, Middle, Las	t)	Man	ager	18. Mother's Nan	un		ırname)		
should and Men s marke umatic	은	Emanuel Curry 19a. Informant's Name/Relationship	(Time Print)	19h Mailin	an Address (Stre	Jessie I et and Number or Ru		er City or T	Town State Zin	Code) 20722	
and 2 s ealth ar n 27 is ner trau		Judy Garrett / D				ad Ct., Ur					
ges 1 a t of He If item or othe		20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □	Removal from State	0b. Place of Dispo- cemetery, cren	sition (Name of natory or other p	lace)	Date	20c. Loca	ition - City or To	wn, State	
it. Pages intment of intant; If it injury or o		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Section 21. Signature of Funeral Section 21.	fy) B	altimore		山 01/(dress of Facilit The	77,2007			taryland	
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be executed cian and purial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.									
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Unknown 2 □ Compare 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown 5 □ Other (specify) 9 □ Unknown 9 □ Unknown 1 □ Unk							23d. Date of delivery Month Day Year		
quires that an signed b	by	Part II. Other significant conditions	given in Part I.		obacco use /es 2 🖼		ne cause of death?				
The law re ate has bee	Completed	Hyrist	ens in				24a. Was autop perfo 1 □Yes		24b. Were auto prior to condeath?	psy findings available mpletion of cause of	
Iclan; certific ector,	Be	25. Was case referred to predical examiner?	Hospital:		10	ther:	ath (Check only o	,			
ding Phys h. After this funeral dir	tion: To	1 Yes 2	28a. Date of Injury (Month, Day, Ye	2 R/Outpatier 28b. Time of Injury	28c. In	4 LI Nursing F	T	ome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred			
tal or Atter rs after dea al Director ed in by the	Certification: To	3 Suicide 6 Could not l	eet, factory, offic	e	28f. Location (8 City or Tov	Street and i vn, State)	Number or Rura	l Route Number,			
the Hospi iin 24 hour the Funer ipletely fill	Medical	(Check only 2 Medical Exa	hysician: To the best of m iminer: On the basis of exa and manner stated.		vestigation, In m	y opinion, death occu		date and p	lace, and due to	the cause(s)	
To 1 with To 1	M	29b. Signature and title of certifier	Berke ,	DD.		nse number		29d. Date	signed (Month,	Day, Year)	
4		30. Name and address of person who	V 00 15	walk	Print)	e belt	timelo v	へり.	21-20	>8	
Sta Registr		31. Date filed (Month: Day, Year)	32. Registrar's	signature	-						

09-00008 Kim B. Holiday

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2009 00214

	1- For State Registrar	C	ertificate of	Death		Reg	No.		
Physician/ Medical Examiner	Decedent's Name (First, Midd				A Tai	January 1, 4		3. Time of Death 0700 hrs	
	4a. Facility Name (if not institution 1417 Mountmor Cour		.1 = -	4b. City, Town, or Lo Baltimore	ocation of Death		4c. County of De	'A	
Funeral	5. Social Security Number	6. Sex 7. Age (In yr	rs. last birthday)	If Under 1 Year Months Days	If Under 24Hrs	-	(MM/DD/YYYY) 9. I	Birthplace (State or eign	
Director	212-78-6684	212-78-6684 1 M 2XF				Oct 27,	, 1959 Country) Maryland		
any services	Usual Residence of Decedent 10a. State 10b. County	100.0	City, Town or Local	ion				10d. Inside City Limits	
ě .	M 1 1 N		Balti					1 XYes 2 No	
Maryland Maryland d at once.	Maryland N,	/A	Dares	10f. Zip Code		· 10g	. Citizen of What C	ountry?	
the Maryland of or 28a-f sh iffed at once	1417 Mountmor	Court		2121	7		USA		
		12. Was Decedent Ever i		as Decedent of Hisp es, specify Cuban,			14. Race - Am White, etc	nerican Indian, Black,	
or items 23 must be no	1 Never Married 2 X	Yes Z X N	0			Trican, cic.,	Specify: B		
	3 Widowed 4 Di	ivorced If Yes, Give Year or Dates:		Yes 2 X No		work done	Specity: D 16b. Kind of Busine		
5-0036 led within 72 hours after led within 72 hours after lygiene. other than "natural", the Medical Examiner Completed by		ecify only highest grade completed College (1-4 or 5+)		nost of working life.			TOD: Tand of Doome	·	
5-0036 ed within 72 hour lygiene. other than "nature Medical Exau	- Lionomary (o 12	1	Ha:	ir Stylis	t		Beauty	Salon	
5-0036 led within tygiene. other that the Medic	17. Father's Name (First, Middle			1		e (First, Middle, M	aiden Surname)		
	James C. Blu					va Hill	01 T 0	Tie Cada	
O 등 등 표기 _		hnson, Sister					per, City or Town, Si re. Marvl	and 21229	
	20a. Method of Disposition		0b. Place of Dispo	sition (Name of cem		Date	20c. Location - City		
of H = i		on 3 Removal from State	crematory or o	_{ther place)} ematory I	nc. 01	/08/09	Baltimor	e, Maryland	
Baltimo permit. Pag Department Important: injury or of	4 Donation 5 Other 21. Signature of Funeral Service		22	Name and Address					
Balti permit Departin Importe	Thomas Gregor	Komao Du	ju ž	99 Freder	ick Roa	d Baltim	ore, Mary	land 21228_	
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xaminer	Immediate Cause (Final diseas	_{se a.} Hypertensi		oscleroti	c cardi	ovasculai	r disease	Death	
	or condition resulting in death)	Due to (or as a consequent	ce or):						
Jer Jer Jer Jer Jer Jer Jer Jer Jer Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequen	ce of):		31.1	1.7			
red nsit	cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Las	C	ce of):						
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760, ficate be physici the buri	IF FEMALE: 23b. Was decedent pregnant in	23c. If yes, outcome of	pregnancy		Ectopic preg		23d. Date of deli	very Dav Year	
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by the attendin tched for use an Dhysician	1 Yes 2 No 9 🗸 L	9 CHKHOWH				00 Bill		a to the serve of death?	
P.O. Box 68 start the death certify med by the attending detached for use as by Physician		ditions contributing to death but	not resulting in the	underlying cause g	iven in Part I.			e to the cause of death? Probably 4 Unknown	
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Records, The law requires ficate has been signage 2 should be						autop:			
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n of Vit ding Physic L. After this funeral dire		28a. Date of Injury (Month, Day, Year)	28b. Time o		ry at Work?		now injury occurred		
On Conding ath. After the function	1 X Natural 5 Pe	ending		1_\	res 2 No				
ViSion Attende Pirecte in by t	2 Accident In	vestigation 28e. Place of Injury -	At home, farm, str	eet, factory, office b	uilding, etc.	28f. Location (S		r Rural Route Number, City	
Division o septial or Attending hours after death. meral Director: After y filled in by the fune	4 Homicide de	etermined (Specify)							
		Physician: To the best of my kno xaminer:On the basis of examinat	wledge, death occ	urred at the time, da	ate and place, a	nd due to the caus d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)	
To the He within 24 To the Fu complete	one) 2 Medical E 29b. Signature and title of cert	and manner stated.	-2	29c. Licens				(Month, Day, Year)	
O VA	70/	· mcAR		O.C.			January 1, 20	009	
Parit	30. Name and address of pers	son who completed cause of death	(Ite 23a)						
bon	Zabiullah Ali, M.D.	Assistant Medical Exam		enn Street, Balt	imore, MD 2	21201		9	
Stat		6	gnature.	arked					
Registra	T IAM A	0 2000 /2	1. Ja.	COLUMN TO THE PARTY OF THE PART					

			For State Registrar	State of M	arylan	d / Depa <i>Cei</i>	artmen <i>rtificate</i>	t of H e <i>of E</i>	ealth a Death	and Mo	ental Hy	gien Reg. No	^e 20	09	00215
	Physici /Medio		1. Decedent's Name (First, Middle, La CLAUDETTE JOAN HA	,							2. Date of De Month JANUAR	De	ay 200	Year 9	3. Time of Death 7:00 P M
1	Examin		4a. Facility Name (If not institution, give street and number) 584 BRIGHTVIEW DRIVE				4b. City,			of Death			-		OFT.
	Funeral Director		Social Security Number 6. 8		ne <i>(In yrs. l</i> 73	ast birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th		9. Birth	place (State or Foreign
	r the Maryland r 28a-f show	tor	Usual Residence of Decedent 10a. State 10b. County MARYLAND ANNE ARU	JNDEL	1	, Town or Lo									10d. Inside City Limits 1 ☐ Yes 2 X No
	with the	Director	10e. Street and Number	TVE	1		10f. Zip								
936	be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1				lent of Hi	spanic Ori n, Mexicar Specify:		cify Yes or No lican, etc.)		14. Race Black	e - Ameri k, White,	can Indian, etc.
Maryland 21215-0036	filed within 72 hou Hygiene. ther than "natura ent, the Medical E	Completed	15. Decedent's E (Specify only highest gr.	dent's Usua kind of wor DO NOT us HER	k done d	urina mos	t of workin	g	Anne Arunder Anne Arunder Anne Arunder Anne Arunder Begin to Beath Anne Arunder Begin to Beath Anne Arunder Begin to Beath Anne Arunder Begin to Beath Anne Arunder Begin to Beath Anne Arunder Begin to Beath Anne Arunder Begin to Beath Country Begin to Beath Country Begin to Beath Country Begin to Beath Country Begin to Beath Country Begin to Beath Country Begin to Beath Country Begin to Beath Country Begin to Beath Begin to Beath Country Begin to Beath Country Begin to Beath Begin to						
land 2		To Be C	17. Father's Name (First, Middle, Last MICHAEL HUDAK)						er's Name A RIM		, Maide	ń Surnam	e)	
Mar	sho and sm	•	19a. Informant's Name/Relationship												· · · · · · · · · · · · · · · · · · ·
a.	Pages 1 and 2 nent of Health int: If item 27 i iry or other tra		20a. Method of Disposition 1 Burial 2 A Cremation 3 C 4 Donation 5 Qther (Specia	Removal from State		lace of Dispo emetery, crer	sition (Nan natory or o	ne of ther place	9)		ARY 6,	20c. l	ocation -	City or T	own, State
Balti	permit. Pages 1 Department of H Important: If ite any Injury or ot		21. Signature of Funeral Service Lice	nsele		K ² .	RRLES 21 CRA	d Addres AIN H	odick wy.,	FUNE S.E.	ERAL HO	OME, N BU	P.A. RNIE,	MD	21061
I wan in	Physician /Medical Examiner	Je.	23a. Part 1. Enter the disease, or composition shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if you leading to immediate	plications that cause one cause on each li a	ne. a consequ	LU uence of):			g, such as	cardiac o	respiratory a	arrest,			Approximate Interval Between Onset and Death UCAVJ
8760,	ficate be executed physician and s the burial-transit	dical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as											
O. Box 6	eath certii attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant	2 🗌 Fetal	I death 3	∃Ectopic p ∃Other (sp		,						*
rds, P.	w requires that the dispersion is been signed by the should be detached	<u>م</u>	Part II. Other significant conditions	contributing to death t	out not resu	ulting in the u	nderlying c	ause give	en in Part I	,					
Vital Records,	The law ate has t	Completed									24a. Was auto perfi 1 □ Yes	psy ormed?	F	rior to co death?	ompletion of cause of
	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 🗆	ER/Outpatie	nt 3□DC	Othe	r.		(Check only		6 □Oth	er /Spac	(6.1)
ion of	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Da	ury	28b. Time o Injury		8c. Injury Work		2					
Division	al or Atto s after de al Directo	Sertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of in	jury - At ho tc. <i>(Specif</i> j	ome, farm, str y)	eet, factory	, office		2	8f. Location City or To	(Street a wn, Sta	and Numb te)	er or Rui	ral Route Number,
	the Hospital hin 24 hours a the Funeral I upletely filled	Medical (of examina										
	To the common co	×	29b. Signature and title of certifier	uilly le	\sim		290	. License	number Q	30		29d. D	ate signed	2.0	Day, Year)
	10		30. Name and address of person who	completed cause of	death (Item	1 23a) (Type,	Print) BE	stac	ate 1	Rd.	An	Na	poli	is, i	Md.
	Sta Registi		31. Date filed (Month, Day, Year) JAN 0 8 20	32. regist	rar's Signa	ture 1. And	wes	3							

State of Maryland / Department of Health and Mental Hygieneo o o

		•	for State Registrar	Clate of Wa	Ce	rtificate of L	Death		eg. No.	00216
	Physicia		Decedent's Name (First, Middle, Last	William	David 1	Hamilton		2. Date of Deat Month Januar		3. Time of Death 5:15 A M
	/Medic Examin		4a. Facility Name (If not institution, give Genesis Heritage		Center		Location of Death		4c. County of Deal	
Ī	Funeral Director		5. Social Security Number 6. S		(In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 2	Year) 9. Bird Co	thplace (State or Foreign ountry) nnsylvania
	sryland show	_	Usual Residence of Decedent 10a. State 10b. County	+ i	10c. City, Town or L	ocation	Edgemer	e		10d. Inside City Limits 1 □ Yes 2 ☒ No
	the Ma	recto	Maryland Bal 10e. Street and Number	timore	·	10f. Zip Code	Dagomor		0g. Citizen of What Co	
	th with 23a or	ral Di	6927 River Drive	Road			21219		United Sta	ites
9	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. I is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Examinar must be incitived at	y Funeral Director	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 N If Yes, Give	lo	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🖾 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	e, etc.
	72 hour	ted k	15. Decedent's Ec (Specify only highest gra	Year or Dates:	WWII	edent's Usual Occupa	ation	ina	16b. Kind of Business	White Industry
17	within 7 ene. than "r	Completed by	Elementary/Secondary (0-12) 8 Years	College (1-4or 5-	+)	e kind of work done of DO NOT use retired e1 Worker)	ling	Steel Inc	lustry
2	other vent, II	Be Co	17. Father's Name (First, Middle, Last)		500	- WOLKEL	18. Mother's Nam		Maiden Surname)	
yla	ould be d Menta narked natic e	To	Robert David		100.00.00			a L. Ki		7-0-4-
N N	permit. Pages 1 and 2 should be Department of Heath and Menta Important: If item 27 is marked any Injury or other traumatic evonce.		19a. Informant's Name/Relationship (Mrs. Patricia Ma			6 McComas		indalk, l	r, City or Town, State, . Maryland	21 2 2 2
ָ ט	ges 1 a t of He If item or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State		osition (Name of ematory or other plac			20c. Location - City or	·
	nit. Pag artmen ortant: Injury e.		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer			Cemetery 22. Name and Addres			Baltimore Dundalk, I	
2	permi Depar Impor any Ir		Strego E.	Kent	7	922 Wise	Ave. Dur	dalk, Ma	aryland 2	1222
			23a. Part 1. Enter the disease, or com shock, or he train. List only Immediate Cause (Final	plications that caused one cause an each lin	the death. Do not en	nter the mode of dyin	g, such as cardiac	or respiratory arm	est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as	a consequence of):	UF	RE	-101	V	27 EAKS
	Examiner	Ļ	Sequentially list conditions,	b						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or ac t	ā conceytence vi):					
, C	icate be executed physician and the burial-transit	I Exa	resulting in death) Last	Due to (or as	a consequence of):					
00100	rtificate I ng physi as the b	Medical I		⊾d					1	
YOU	eath cert attending for use a	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐ Ectopic pregnanc	у		23d. Date of de Month	livery Day Year
5	the dea y the a iched fo	Physician/	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at 9 ☐ Unknown	t time of death 5	Other (specify)				
coids, r	Physician: The law requires that the death certificate be executed tribic certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions of	contributing to death be	ut not resulting to the	undarlying cause give	en in Part I		bacco use contribute t es 2 □ No 3 □ P	othe cause of death? robably 4 ☐ Unknown
2	aw requast been 2 shoul	Completed			V			24a. Was a	n 24b. Were a	utopsy findings available completion of cause of
ב ה	: The l	Com						autops perfori 1 □Yes	med? death? 2 No 1 ☐ Yes	· <u> </u>
<u> </u>	rsician: The s certificate lirector, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	ent 2 ☐ ER/Outpati	ent 3 DOA Oth	26. Place of Deater:		ne) ence 6 ☐ Other (Spe	noifu)
5	Jing Phys J. After this funeral dii	ı⊢.	27. Manper of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da		of 28c. Injur Work	y at </th <th></th> <th>ow injury occurred</th> <th>Schiy)</th>		ow injury occurred	Schiy)
VISION	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification:	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Inju	ury - At home, farm, s		Yes 2□No	28f. Location (Sincity or Town	treet and Number or R	ural Route Number,
5	spital or lours afte neral Dir filled in		29a. Certifier 1 CertifyIng Pl	hysician: To the best	of my knowledge, dea			, and due to the o	cause(s) and manner a	
	the Ho nin 24 h the Fui npletely	Medical	one)	miner: On the basis o and manner sta					date and place, and du	
)	Co. 4 with	2	29b. Signature and title of certifier	tingh r	M.D.	29c. Nicens	1416	0	ANVAR	102,2009
6	ot 1		30. Name and adhese of person who	AT TIM	RE DO	ARYIN	-ARIT	CHIE	-HGHV	VA9,
	Sta	ite	31. Date filed (Month, Day, Year)	_ /A	ar's Signature	Ne de la la la la la la la la la la la la la	NY Z	- land)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#7 per EH G887 1/8/09 WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician J. HENRY ANUARY 1 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 1507 N. Kenhill Ave. Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1□M 2₩F 29,1929 Va. Director Sept. 227**-**34-5158 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County a or 28a-f show t be notified at 1 □XYes 2 □ No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a t any Injury or other traumatic event, <u>the Medical Examiner must b</u> price. 1507 N. Kenhill Ave. 21213 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Supervisor <u>Veteran</u> Admin 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nanny Taylor William Gregory 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher Ave. Balto. MD 21214 Moses Gregory/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GarrisonForestVetCemJanl3,2009^{Owingsmills,MD} mature of Fineral Service License 22. Name and Address of Facility
CALVIN B SCRUGGS FUNERAL HOME
1412 E. PRESTON ST. BALTO. MD 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROTIC CARDIOVASCULAR HEART DISENTE **Physician** 204125 /Medical Due to (or as a consequence of): **Examiner** DIABETES MELLITUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner HYPERTENSION To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 menths? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by DIABETES 1 Tyes 2 KNO 3 Probably 4 Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes Medical Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Matural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D37370 JANUARY 2,2009 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROYMOND [AYLOR MD. 2000 E. EAGER ST BALTO. MD 21202

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

09-00141

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

a Harris		State of Maryland / [1-For State Registrar	Department of Certificate of		Hygiene 2009 002
Physicia cal Exami	an/	1. Decedent's Name (First, Middle, Last) Jo Sh ua	,	ris	2. Date of Death Month Day Year January 5, 2009 3. Time of Death 1719 hrs
		4a. Facility Name (if not institution, give street and number) Sinai Hospital		4b. City, Town, or Location of De Baltimore	4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (1) 4. 2 F	n yrs. last birthday) Yrs.		Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
ages I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. I: If item 27 is marked other than "natural", or items 23a or 28a-f show any other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	10e. Street and Number 23 E. Mad Jan 11. Marital Status 1 Never Married 2 Married 1 Yes 2 3 Widowed 4 Divorced of Yes, Give Year 15. Decedent's Education (Specify only highest grade completementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) 20a. Mathod of Disposition	Address (Street and Number of P. madison ition (Name of cemetery,	white, etc. Specify: Specify: Of work done retired) Temp. Abency ame (First, Middle, Maiden Surname) Lina Harris or Rural Route Number, City or Town, State, Zip Code)	
permit Pages Apparament of Medical Medical Medical Medical Medical	Examiner	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Doepsee 23a. Papt I. Enter the disease, or complications that caused the failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated C.	e death. Do not enter the Wounds	arnel Com. 1- Jame and Address of Facility of Progress Try Progress	270 Fred trution Pass F.H. Balto, and. 21229 ac or respiratory arrest, shock, or heart Approximate Internet Death
he death certificate be executed the attending physician and hed for use as the burial - transit	hysician/Medical Exa	events resulting in death) Last Due to (or as a consequence of the co	of pregnancy	tal death 3 Ectopic pre	23d. Date of delivery Month Day Year
ng Physician: The law requires that t After this certificate has been signed by ineral director, page 2 should be detac	n: To Be Completed by P	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month Day Yee) Jan 5, 2009	2 ✔ ER/Outpatient	26.Place of Death (Che	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 2 2 No 2 2 No 2 2 No 2 2 No 2 2 No 2 2 No 2 2 No 2 2 No 2 2 No 2 2 No 2 2 No 2 2 No 2 2 No 2 2 2 2
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: completely filled in by the ft.	Medical Certification:	4 V Homicide Could not be determined (Specify) Loca 29a. Certifier 1 Certifying Physician: To the best of my k	Street		28f. Location (Street and Number or Rural Route Number, C or Town, State) 3700 Reisterstown Road, Baltimore, MD and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)
- » - 8	Me	29b. Signature and title of certifier 30. Name and address of person who completed cause of dea	th (Item 23a)	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) January 6, 2009
7		Laron Locke MD. Assistant Medical Exam	niner 111 Penn	Street, Baltimore, MD 2	21201
St Regist	ate	31. Date filed (Month, Day, Year) 32. Registrar's	Signature	w. A.	

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene

yrone dames	1- For State Registrar Grant of Maryland / Department of Health and Mental Hygle Certificate of Death	Reg. No. 200	9 0021
Physician/ fledical Examiner	1 1. Decedent's Name (First, Middle,Last) 2. Da	te of Death onth Day Year nuary 4, 2009	3. Time of Death 1029 hrs
,	4a. Facility Name (if not institution, give street and number) Johns Hopkins Hospital 4b. City, Town, or Location of Death Baltimore	4c. County of Dea	h
Funeral Director	212-80-8128	9. Bate of Birth (MM/DD/YYYY) 9. B C C	rthplace (State or Foreign ountry) MD
nd Ce.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Md Baltimore		10d. Inside City Limits XX Yes 2 No
death with the Maryland or items 23a or 28a-f show must be notified at once.		10g. Citizen of What Co	untry?
	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes 3 No specify:	, etc.) White, etc.	rican Indian, Black,
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or other tranmatic event, the Medical Examiner To Be Completed by	or Dates:	Specify: Bla	
21215-0036 uld be filed within 72 bour Mental Hygiene. marked other than "matu c event, the Medical Exar To Be Completed	12th Linen Distribution 17. Father's Name (First, Middle, Last) 18. Mother's Name (First	Hospital , Middle, Maiden Surname)	
21215-00 ould be filed with a Mental Hygien is marked other ite event, the March To Be Com	Elroy Witherspoon Dora Lee James	The second secon	e. Zip Code)
MD 2 should be s	Latisha James - Daughter 509 N.Bradford Street Baltimor	re, MD. 21205	
Baltimore, MD 21215-C pernit Pages I and 2 should be filed v Department of Health and Mental Hygi Important: If item 27 is marked oth injury or other tranmatic event, the 1 To Be Co	1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Garden Of Faith 1-10- 2		
Balti permit Departu Import injary	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home 638 N. (
Physician /Medical xaminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resp failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Intracerebral Hemorrhage Due to (or as a consequence of):	iratory arrest, shock, or heart	Approximate Interval Between Onset and Death
Ja	Sequentially list conditions. b		-
ted Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (cr as a consequence of):		==
execuian and and and Ital			
box 68760, the death certificate be the death certificate by the attending physic ched for use as the burn Physician/Med		23d. Date of delive Month	ry Day Year
O. Bo at the dea lby the a lached fo		23e. Did tobacco use contribute t	o the cause of death?
ords, P.O. w requires that the speen signed by should be detacl	Hypertensive cardiovascular disease	1 Yes 2 No 3 Pro	obably 4 Unknown
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. The fine Funeral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as it edical Certification: To Be Completed by Physician/	1	autopsy prior to death? Yes 2 No 1	completion of cause of
Vital vysician this cert directo			er:
ion of Vit tending Physic tent. After this s the funeral dire ation: To E	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	Describe how injury occurred	
Division o spital or Attending nours after death. neral Director: Aft filled in by the fune Certification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Location (Street and Number or For Town, State)	tural Route Number, City
Divisior To the Hospital or Attend within 24 hours after death The Funeral Director: completely filled in by the Medical Certificatic		ime, date and place, and due to	he cause(s)
	29b. Signature and title of certifier 29c. License number O.C.M.E.	29d. Date signed (Manuary 5, 2009)	
5	30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	1201	
State Registrar	Address and the second		

Amend #2, &29d per DVR g887 1.8.09 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00220 Certificate of Death Reg. No. 2009 Year 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Phyllis Ann Jowanowitch JAMANT 0340AM /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Burnic BAltimure Washinton Merical Center Glen Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 7-1-1932 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖺 F Months Days Hours Min. 217-28-8943 76 Director Usual Residence of Decedent Maryland 10b, County 10c, City, Town or Location 10a State 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Linthicum MD Anne Arundel Funeral Director 1 ☐ Yes 2 ☐XNo the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21090 USA 689 Andover Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ANo 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Interest if item 27 is marked other than "natural", or ite any or other traumatic event, I'm Madical Exprimerary or other traumatic event, I'm Madical Exprimerary 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐Never Married 2 ☐ Married 1 □Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Specify: white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Home Owner College (1-4or 5+) homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Nelson Layman Smouse ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 689 Andover Rd., Linthicum, MD 21090 19a. Informant's Name/Relationship (Type. Print) Mr Robert Minnick / son item 2. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition Department of Important: If it any Injury or once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 1/8/2009 Catonsville MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kirkley-Ruddick Funeral Home PA M01364 421 Crain Hwy SE Glen Burnie MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician (OSONAry 20415 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit most Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 Tho
9 Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 156 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of con 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington Medical 3f. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 8 2009 JAN Registrar

JOWANOL Hich,

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2009 00221 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 23:10 PM rnon 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Burnie Anne Arundel Baltimore-Washington Medical Center (In yrs. last birthday) 78 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 15, 1930 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 M 2 □ F Months 218-26-6400 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the firedical Experience must be notified at Glen Burnie 1 ☐ Yes 2 No Anne Arundel Funeral Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7615 Beaver Road 21060 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Mores 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, the Iffa Juce. College (1-4or 5+) Elementary/Secondary (0-12) Proctor & Gamble Co. Machinist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Muir Sr. Laura Vernon L. Johnson ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7615 Beaver Road, Glen Burnie, Maryland 21060 Geraldine D. Johnson (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 01-09-09 Bayview Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility CCULLY—Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 21. Signature of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List only one of use on each line. Approximate Interval Between Onset and Death ease or condition resulting in death) **Physician** 1000 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence 1) Examiner the attending physician and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 1 ☐ Yes 2 🗹 No SINI 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗖 No 1∐Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA Certification: To 27. Manny of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 □Yes death. 2 Accident Director: completely filled in by the Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

104

State Registrar Date filed (Month, Bay, Year)

JAN 0 8 2009

Server J. Janes

30. Name and address of person who completed cause of death

DHMH 17 Rev 1/2001

tem 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 LYDIA JORDAN JAN. 6, 5:55 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GILCHRIST CENTER FOR HOSPICE TOWSON BALTIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 - M X X GERMANY 62 Director 216-50-1982 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ir than "natural", or items 23a or 28a-f sho Director 1XX es 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 809 FAGLEY STREET 21224 Funeral U.S.A. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes XXNo Specify Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 WAITRESS RESTAURANT/BAR is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be f Department of Health and Mental Important: If item 27 is marked or TONY W. LAWRENCE **HELENA** FEDJ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DENISE WINTERLING/DAUGHTER 7904 OLD HARFORD ROAD, BALTIMORE, MD. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ANDREW'S CEMETERY 1/10/09 BALTIMORE, MD. 21. Signature of Fundamental Service Licenses LTLLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 ☐ Other (specify) P.O. 9 Unknow signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy certificate 1 ☐Yes 2 ☐No 1 □Yes To the Hospital or Attending Physiclan: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 \subseteq Nursing Home 5 \subseteq Residence 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Division Natural 5 ☐ Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No the 1 after death 3 ☐ Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated 29b. Signature 29c. License number 29d. Date signed (Month, Dav. Year)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

JAN 08 2009

6701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18S

Registrar's Sign

(W)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-00083 State of Maryland / Department of Health and Mental Hygiene Ja'nya Johnson 2009 00223 1. For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day January 3, 2009 1053 hrs Medical Examiner JA'NYA ASHLEY JOHNSON 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore **Baltimore County** St. Agnes Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** Months Days Hours Min Director Country MARYLAND 10-10-2008 M 2 X F Yrs. 215-83-2182 Usual Residence of Deceden 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 1 X Yes 2 No 23a or 28a-f show notified at once. BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21207 USA 924 MASEFIELD RD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) X Never Married Armed Forces Yes 9 Yes 2X No specify: Specify: BLACK Divorced If Yes. Give Year Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.

tant: If item 27 is marked other than "natural",
or other traumatic event, the Medical Examiner ò 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 infant -0--0infant 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) TENNILLE ALLEN JOHNNY JOHNSON 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 924 MASEFIELD RD. BALTIMORE, MARYLAND 21207 JOHNNY JOHNSON (FATHER) 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) X Burial Cremation Removal from State 1-10-2008 BALTIMORE, MARYLAND KINGS MEMORIAL PARK Other Specify HIBN F3. Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and re. List only one cause on each line /Medical Death Sudden unexplained death in infancy Imme ate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed AMENDED 23a,27,28a-f, perME, g889 3/11/09 TT Physician/Medical X UNPENDED attending physician a Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth Fetal death 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, P.O. ⋧ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available peen autopsy prior to completion of cause of has performed? death? No ✓ Yes 2 Yes 1 🗸 certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 examiner? Other; DOA Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 this 1 V Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: Natural Yes 2X No lunk Director: d in by the Pending Fd 1/3/09 Fd 9:30 am 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 924 Masefield Rd. Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be 3 determined (Specify) residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

within 24 hours after death.

To the Funeral Director:

Melissa Brassell, MD 31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

32. Registrar's Signature

Assistant Medical Examiner

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

January 4, 2009

Granel

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 00224 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Helen Kinsella January 4, 8:30 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2842 Salem Bottom Road Carroll Westminster 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/18/1933 6 Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) **Funeral** Months Days Hours 1 □ M 2 🕅 F 75 Maryland Director 218-26-3682 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Me Kal Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No MD Baltimore Towson Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 409 Virginia Avenue 21286 U.S.A. Funeral 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael McDonnell Julia O'Brien ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur M. Kinsella, Jr. , Son 2842 Salem Bottom Road, Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Svc. Corp. 01/07/2009 Towson, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Leopard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee estandua 23a. Part1. Enter the disease, or complicative, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician +4 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for ear a consequence of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 brous after death.

Within 24 brous after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Vear 4 Pregnant at time of death 5 ☐ Other (specify) 9∏tJnknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mapmer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year)

EVANGELOS 31. Date filed (Month, Day, Year) JAN 0 8 2009 Registrar

29b. Signature and title of certifier,

GNOS 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

01-05-09

YORK Rd, TOWSON, MD, 21201

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cia		1. Decedent's Name (First, Middle, Last)							2. Date of De Month	Da		Year	3. Time of Death	
ica		Albert Raymond Lo			4h City	Town or	Location o	f Death	Januar		, 200		9:21 P [™]	-
ine	er	4a. Facility Name (If not institution, give si		tor	,,,	n Bur	_	, Douil			Anne		ide1	
-		Baltimore Washing 5. Social Security Number 6. Sex			If Under	1 Year	If Under 2		8. Date of Bird (Month, Da	th	T	9. Birthp	place (State or Foreign	-
		218 44 1320	M 2□F 61	Yrs.	Months	Days	Hours	Min.	Sept. 3			Cour	land	
		Usual Residence of Decedent	10c City	, Town or Lo	cation							1	10d. Inside City Limits	_
	2	10a. State 10b. County	Too. Oity	, TOWITOT LO	cation								1 □Yes 2√∑No	
	Director	Maryland Anne Arur	ndel Glen	Burn	10f. Zip	Code				10a. C	itizen of W	/hat Cour	ntrv?	_
			A∞+ Ti		210						ited		,	
	Funeral	101 Summit Ave. 2	2. Was Decedent Ever in U.S.	3. 13.			spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)		14. Race	- Americ	can Indian,	-
	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	i i	ir Yes, spe 1 □ Yes		Specify:	i, Puerto	Hican, etc.)		Specify.	k, White,	etc.	
1	Completed by	3 ☐ Widowed 4 🙀 Divorced	Year or Dates:									Whit		
1	lete	15. Decedent's Educ (Specify only highest grade		16a. Deced	dent's Usu: kind of wo DO NOT u:	ork done d	uring mos	t of work	ing	16b.	Kind of Bu	siness/In	dustry	1
1	m	Elementary/Secondary (0-12)	College (1-4or 5+)	Cutte		se remed)	,			_ ر	lothi	na		
	ပိ	11 17. Father's Name (<i>First, Middle, Last</i>)		Cucce	; <u>L</u>		18. Mothe	er's Name	e (First, Middle					
1	To Be	Albert R. Lowman	, Sr.			}	Dore	othy	Treva					
	-	19a. Informant's Name/Relationship (Typ	oe. Print)	19b. Mailir	ng Address	s (Street a	and Numbe	er or Rur	ral Route Numb	er, City	or Town,	State, Zip	code)	
		Dorothy Gover / Co	mpanion	101 5							rnie,		21060	
1		20a. Method of Disposition 1 □ Bilirial 2 ☑ Cremation 3 □ Re	emoval from State	lace of Dispo emetery, crei	osition (Nat matory or c	me of other place	e) :		Date 7	20c.	Location -	City or To	own, State	
		4 □ Donation 5 □ Other (Specify)	Met	ro Çre					2009'	Cat	onsv	ille	, Maryland	
i dire		21. Signature of Fun ral Service License	90	K	2. Name <i>a</i> Kirkle 121 Ci	ey-Ru	ıddic	k Fu	neral H Glen		, P.A		21061	
1		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death							rrest,			Approximate Interval Between	
1		Immediate Cause (Final disease or condition	Myocco	bil	T_{i}	to	Ch	con				_ [Onset and Death	
1		resulting in death)	Due to (o) as a consequ	uence of):									Q	_
i Č	<u></u>	Sequentially list conditions, b	Due to (or as a consequ	sence of):								-		_
٦	Examiner	Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	zence or).										
	xar	that initiated events cresulting in death) Last	Due to (or as a consequ	uence of):									-	
	dicall	L _d	I											_
	ledi													
ļ	an/N	23b. was decedent pregnant	3c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Fetal		⊒Ectopic p	regnancy					23d. Dat	te of deliv	ery Day Year	
	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5[Other (s	pecify)					IVIO	1101	Day Toal	
		Part II. Other significant conditions cor	ntributing to death but not resu	ulting in the u	ınderlying	cause give	en in Part I	l.	23e. Did	tobacco	use cont	ribute to 1	the cause of death?	_
	Completed by								15€	Yes	2 🗌 No	3 ☐ Pro	bably 4 Unknown	
	lete								24a. Was		24b.	Were aut	opsy findings available ompletion of cause of	
	omp								auto perf 1□ Yes	opsy ormed: 2 X	? (prior to co death? 1 ∐Yes	ompletion of cause of 2□ No	
	Be C	25. Was case referred to medical					26. Place	e of Dea	th (Check only	-7-	40	1 1 1 1 1 1 1	20110	
	To E	examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 ☐ Inpatient 2 🙀	ER/Outpatie	nt 3 D	OA Oth	er: 4 🗆 Nı	ursing H	ome 5□Res	idence	6 □Oth	er (Spec	ify)	
		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of M	28c. Injur Worl 1 □	yat k? Yes 2 □	No	28d. Describe	how in	jury occuri	red		
	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specify	ome, farm, st	reet, factor	ry, office			28f. Location City or To	(Street own, St	and Numb ate)	er or Rui	ral Route Number,	
	Medical C		sician: To the best of my kno iner: On the basis of examina and manner stated.											
	Mec	29b. Signature and title of certifier	and manuer stated.		29	9c. Licens	e number			29d. [Date signe	d (Month	, Day, Year)	
		> M.//.	1-			D454	75			,Т:	nnar	v 7	2009	
		30. Name and address of person who co	ompleted cause of death (Item	n 23a) (Type		D454	15				anual.	<i>I</i> ''	2003	-

State Registrar

JAN08 DHMH 17 Rev 1/2001

Mohammad Rahnama,

31. Date filed (Month, Day, Year)

9512 Harford

32. Registrar's Signature

Suite 4;

Parkville, MD

21234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 0 9 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** ARTHUR LONG 2009 1 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CROMWELL NURSING HOLE MINTIMONE 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 24, 5. Social Security Number . Age (In yrs. last birthday) **Funeral** 232-22-0168 Director Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medic of Examiner must be notified at 1 ☐ Yes 2 No MD Baltimore Parkville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 8510 Willow Oak Road U.S.A. ı 2 should be filed within 72 hours after death v n and Mental Hygiene. 'Is marked other than "natural". or Heme 22° Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: 2 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Technical Publication Writer Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Lindsley Long, Sr. Margaret Marie Adams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any Injury or other traum once. Luciel M. Long / Wife 8510 Willow Oak Road, Parkville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Hilltop Service Corp. 1-8-09 Towson, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Fungral Service Licensee Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIL 244 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-transit Due to (or as a consequence of) attending physician use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Junknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manne 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

3altimore, Maryland 21215-0036

hours after death. Ineral Director: After this o y filled in by the funeral dire within 24 hours a

To the Funeral C

completely filled

State Registrar

Medical

31. Date filed (Month, Day, JAN 0 8 2009

29b. Signature and title of certifier

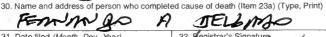
3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

6 ☐ Could not be

determined



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

32+1+ 1/5/2009 8710 EMGE NO BATINONE MO 2172

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D32717

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

MANCEL	-	Lee MITCheLL		
09-00037 UNK UNK		Please Type or Print in Black Indelible Ink. E		
ONK ONK		State of Maryland / Department of Heal For State Certificate of Deat.	h	2009 0022
Physician		egistrar Decepent Name (First, Middle,Last)	2. Date of Death	
Medical Examine	er	Marcel Lee Milchell	January 2,	
	4	a. Facility Name (if not institution, give street and number) 4b. City, 1 1100 block Orleans Street Baltin	Town, or Location of Death	4c. County of Death
Funeral				n(MM/DD/YYYY) 9. Birthplace (State or
Director		2/2-25-4/2/R 1×M 2 F 20 Yrs. Month	s Days Hours Min. Aug	3 198 Foreign Country) Marylan
	_	Isual Residence of Decedent		
ow an		0a. State 10b. County 10d. City Town or Location PAIT, mo	NP,	10d. Inside City Limits 1 Xyes 2 No
aryland Sa-f sh	Director	0e. Street and Number / 10f. Zip	Code 10	g. Citizen of What Country?
15-0036 filed within 72 hours after death with the Maryland I Hygiene. Id other than "natural", or items 23a or 28a-fshow any i, the Medical Examiner must be notified at once.		2843 Federal Vtreet	212/3	USA
th with	Funeral		ent of Hispanic Origin? (Specify Yes or No- fy Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
er deal		1 Yes 2 No 1 Yes 2 No	No specify:	Specify: Dlack
nurs afi itural'	<u>a</u>	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual	Occupation (Give kind of work done	16b. Kind of Business/Industry
6 172 ho an "ua	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) //	rking life, DO NOT use retired)	NA
within giene.	ğ -	7. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, N	faiden AuroameV
21215-0036 uld be filed within 7 mental Hygiene. event, the Medica	Be	Stanley T. Stanfield	Melindas	Witchell
		9a. Intermant's Name/Relationship (Type, Print)	S (Street and Number or Rural Route Num	ber, City or Town, State, Zip Code)
e, MD 1 and 2 sho Health and ritem 27 is	ŀ	14nn; e J-fan C; e/d (MOHRA) / 9 J. 20a. Method of Disposition (Na	me of cemetery, Date	20c. Location - City or Town, State
More Pages 1: Pent of H ant: If it		1 Burial 2 Cremation 3 Removal from State frematory or other place	Tonotas 19/09	Baltimore Ad
Baltimore, permit. Pages I an Department of Hee Important: If itee	-	1. Signature of Funeral Service Licensee 22. Name and	Address of Wility	e. Fineral to me
Per Det liji	1	Magueline & France 374	& N. Furton Ave	BAHO, Md
Physician /Medical	X	39 Part I. Enter the disease, or complications that caused the death. Do not enter the mode failure. List only one cause on each line.	of dying, such as cardiac or respiratory arre	est, shock, or heart Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		Death
		Sequentially list conditions, b		
	Ę١	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated		
		events resulting in death) Last Due to (or as a consequence of):		
// ficate be execute g physician and sthe burial - tran	sician/Medical E	d. UNPENDED AMENDED		
760, cate be physici he buri	Med	F FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
Sox 687 leath certific	ian/	3b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Sp.		Month Day Year
Box 68760, e death certificate b the attending physical contracts of for use as the but	Physic	1 Yes 2 No 9 Unknown 9 Unknown		
s, P.O. irres that the signed by 1	by P	Part II. Other significant conditions contributing to death but not resulting in the underlyin		bacco use contribute to the cause of death? 5 2 ✔ No 3 Probably 4 Unknown
ords, F w requires is been sign	ted			THE RESIDENCE PLANTS AND THE PARTY OF
COTC taw re thas be	Completed			rmed? death?
Rec n: The l tiffcate or, page	O O e	25. Was case referred to medical	26.Place of Death (Check only one)	2 No 1 Yes 2 No
i of Vital Rec ing Physician: The After this certificate uneral director, page	To Be	examiner?	DOA Other Nursing Home 5	Residence 6 V Other: Scene
Division of Vital Records, tal or Attending Physician: The law requirers after death all Director: After this certificate has been sited in by the funeral director, page 2 should be	Ë	27. Manner of Death 28a. Date of Injury (Month Day, Year) 28b. Time of Injury (Month Day, Year) 0450 bre	Subject sho	now injury occurred t
Sior Attend death ector: by the	catic	2 Accident Investigation 280 Place of Injury At home form street factor	1Yes 2 V No	Street and Number or Rural Route Number, City
Divi	Certification:	3 Suicide 6 Could not be determined (Specify) Parking Lot	or Town, S	
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the	ne time, date and place, and due to the caus	e(s) and manner as stated.
Division To the Hospital or Attendit within 24 hours after death To the Funeral Director: A	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in mand manner stated. 29b. Signature and title of certifier 25	ny opinion, death occurred at the time, date	and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
		23	O.C.M.E.	January 2, 2009
B	ŀ	30. Name and address of person who completed cause of death (Item 23a)		
J			Street, Baltimore, MD 21201	
Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	P	
		THE REST OF THE PARTY OF THE PA		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 00228 1 - State Registra Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician Norman Alexander Napper 1;25 D. M 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown Baltimore Seasons Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F 215-78-4674 46 Yrs M Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shore Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo MD Harford Edgawood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 2304 Kealeway 21040 Funeral 12. Was Decedent Ever in U.S. Armed Forceş? 1 ∐Yes 2 ∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or ite 1 ☑ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. African-American Specify: þ 3 Widowed 4 Divorced ntal Hygiene. ed other than "natura event, ine Medical Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Cab Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James C. Napper Sr. Margaret Ann Allen ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type. Print) 715 Surmit Chase Drive., Reading PA 19611 Margaret Ann Napper/ Mother Department of Heal Important: If item 2 any Injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State King Menorial Park 1-8-09 Woodlawn, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. re of Funeral Service Licenses 9200 LibertyRoad, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death immediate Cause (Final **Physician** Metastatic non-small disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) signed by the a P.0. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has I rector, page 2 s performe 2 No 2 🗌 No 1 □ Yes 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other Spec 1 Yes Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending ours after death.

neral Director: A
filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 [TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely fi Medical

0

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifie

MS KajapuluseMD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 200, Reisterstown, MD. 21136 N.S. Rajapaksemo 32. Registrar's Signature JAN 0 8 2009

29c. License number

D0057465

29d. Date signed (Month, Day, Year) 1/3/09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 30 per dyr 8887 1-8-09 vt
State of Maryland / Department of Health and Mental Hygiene 0 0 9 00229 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Vare LYNN VICKIE 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** tages town County Washing to washing ton Ites pita If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1 □ M 2 □ 577-78-3674 April 13,1955 ND Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be nottined at 1 Pres 2 □ No Director Jashington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 12138 21740 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Dres 2 □ No Parmy If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 Yes 2 No Specify þ 3 Widowed 4 ☐ Divorced Whit Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any Injury or other traumatic event in any Injury or other event in any Injury or o Elementary/Secondary (0-12) College (1-4or 5+) Sales tn 10 ler K 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be urner ပ 101 5 19b. Mailing Address (Street and Number or Rural Rou Number, City or Town, State, Zip ode) 19a. Informant's Name/Relationship (Type. Print) Point Stotler Hagerstown Shane 19138 Walnut 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State etro Crematory 1-15-09 4 Donation 5 Dother (Specify) Baltimores 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ILAM 1232 Midvalley Dr. Jessup, PA 18434 23a. Part 1. Ent. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, the eart failure. List only one cause on each line. Immediate Cause (Final intra-cerebra hemorrhage **Physician** acute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 3 weeks Cerebral arter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) the detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Atter this certificate has been si funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident sompletely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🚅 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and trile of certifier 29c. License number Jan 01, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tolmes MI 17 Western Maryland Pkwy. #100 Hagerstown, Md. 21740 31. Date filed (Month, Day Year) 32 Registrar's Signature State carle Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Mar State Amend Items 2,29d per Registrar	yland / Depa dr., g893. <i>Cei</i>	tificate of D	ealth and Death		<u> </u>		230
44	Physici /Medic		1. Decedent's Name (First, Middle, Last) FRANUS	NA	DOLNY		2. Date of Dea Month	ath01/06/200 Day 95 26		of Death AM
	Examin Funeral Director		4a. Facility Name (If not institution, give street and number) JOHNS MOPKINS BAY VIEW MED 5. Social Security Number 221-24-7836 1XD M 2 F	CAL CENTER (In yrs. last birthday) 71 Yrs.	4b. City, Town, or BALTI MU If Under 1 Year Months Days			h 9. B	ath N/A rthplace (State Country) Arvland	
	Ba-f show	Director	Maryland Baltimore	Oc. City, Town or Loc		e River			10d. Inside 1 ☐ Ye	
46.00	23a or 2		10e. Street and Number 600 Tidewater Lane		10f. Zip Code	21220		10g. Citizen of What C	,	
5-0036	al", or items	by Funeral	11. Marital Status 1 ★ Never Married 2		Vas Decedent of His fYes, specify Cubar I □Yes 2 No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh Specify:		
21215-0036	ne.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years 2 Yea	(Give life. L	dent's Usual Occupa kind of work done du DO NOT use retired) CCOUNTING	uring most of wor	king	16b. Kind of Busines:	s/Industry	nd
land 2	and Mental Hygier s marked other th	To Be C	17. Father's Name (First, Middle, Last) Francis Nadolny, Sr.	20 11		18. Mother's Nan	ne (First, Middle, ella Top	Maiden Surname)	патута	nd
, Mary	of Health and Mitem 27 Is mail item 27 Is mail other traumal		19a. Informant's Name/Relationship (Type. Print) Mr. Stephen Nadolny (Brothe		g Address (Street a.	nd Number or Ru	ıral Route Numbe	er, City or Town, State,		21220
altimore, Maryland	ment of He ant: If item ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State □ Donation 5 ☐ Other (Specify)	Sacred Ht	natory or other place of Jesu	ıs Cem.		20c. Location - City o	Mary1	and
Balt	Depart Import any Inj		21. Sign ture of Funeral Service engle		922 Wise	Ave. Di	undalk,		Inc. 21222	
	hysician /Medical xaminer		23a. Part. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a death)	ular Si		an		rest,	Approxim Interval B Onset and	ate etween d Death MUTES
	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a continuous continuou	consequence of):	ardial 1	injave	tion		+ ni	rurs_
O. Box 6	by the attending prached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of do	elivery Day	Year
rds, P.	in signed build be deta	þ	Part II. Other significant conditions contributing to death but	not resulting in the un	derlying cause giver	n in Part I.	23e. Did to	bacco use contribute es 2 ☐ No 3 ☐ F	o the cause of	
tal Reco	certificate has been s rector, page 2 should	e Completed	25. Was case referred to medical			00 Diago of Dag		sy prior to med? death? 2 X No 1 ☐ Ye	utopsy finding completion of s 2 \(\sigma\)No	s available cause of
Division of Vital Records,	ath. r: After this cer le funeral direct	Certification: To Be	examiner?	2 ER/Outpatient 28b. Time of Injury	t 3 DOA Other	 4 ☐ Nursing H		ence 6 Other (Sp ow injury occurred	ecify)	
Divis	urs after death eral Director: illed in by the		4 Homicide building, etc.				City or Tow			mber,
o the Hos	within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of 2 ★ Medical Examiner: On the basis of e and manner state 29b. Signature and title of certifier	xamination and/or inv	estigation, in my op	inion, death occu	rred at the time, o	date and place, and du	e to the cause	(s)
	~	-	Matam Mb 30. Name and address of person who completed cause of dea	th (Item 23a) (Type. F		-000	J	29d. Date signed (Mon anuary 6	2009	009
Ç	∤ Sta	te	NATALE M BOWMAN JOHNS HOP 31. Date filed (Month, Day, Year) 32. Registrar's	KINS HOSP		NORTHW	OLPESTA	ET BALTIMOR	B, MARYL	4ND 21287

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	for State of Maryland / State Maryland / Registrar		ificate of E			Reg. No 200	9 00231
	Physicia	an	Decedent's Name (First, Middle, Last) NEAL NELSO	NT I	OWINGS		2. Date of De Month JAN .		3. Time of Death 12:20 A
	/Medic Examin		NEAL NELSO 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	DAN.	4c. County of [
	LAGIIIII		CARROLL HOSPICE DOVE HOUSE		WESTMI	NSTER If Under 24 Hrs.	O Data of Div	CARRO	
	Funeral Director		5. Social Security Number 218-34-0231 6. Sex 1 M 2 □ F 7. Age (In yrs. last 71		If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da	iy, Year)	Birthplace (State or Foreign Country) ARYLAND
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, To.	own or Loca	ation				10d. Inside City Limits
	Mary a-f sh	ctor	MD CARROLL HAM	PSTE	AD				1 X Yes 2 □ No
	or 28	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of Wha	tt Country?
	sath w	Funeral	11 01 S. MAIN ST. 11 Marital Status 12. Was Decedent Ever in U.S.	13. W	as Decedent of His Yes, specify Cubar		ecify Yes or No	USA 14. Race -	American Indian,
30	72 hours after death with the Maryland natural", or Items 23a or 28a-f show Jical Extinition must be rediffed at	by Fun	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in 0.5. Armed Forces? 1 ▼ Yes 2 □ No If Yes, Give Year or Dates: 1956		17	n, Mexican, Puerto Specify:	Rican, etc.)		WHITE
15-0036	n 72 hours after death with the Marylan "natural", or items 23a or 28a-1 show "Iral Examinar must be redified at	Completed b		6a. Decede (Give ki.	ent's Usual Occupa ind of work done d O NOT use retired)	ation Juring most of work	ing	16b. Kind of Busin	ess/Industry
7	within iene. than "	dwo	Elementary/Secondary (0-12) College (1-4or 5+)		& AUCTI			AUCTION	CO
פר	e filed al Hyg other vent,	Be C	17. Father's Name (First, Middle, Last)	700				, Maiden Surname) NIA GES	DT T
yian	ould b	2	GUY WASHINGTON OWIN						
<u>a</u> a	d 2 should th and Mei 7 Is marke traumatic			_				er, City or Town, Sta EAD , MD	
e,	s 1 and of Healt item 2 other		20a. Method of Disposition 20b. Plac		ition (Name of atory or other place		Date	20c. Location - Cit	
Ē	9 5 = 5		1 XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) TRINI	TY LU	THERAN	CEM. 1		SMALLWC	
Baltimore,	permit. Pag Department Important: any injury o		21. Signature of Pure fal Service Licensee						L HOME, P.A., MD 21157
ı			23a. Part 1 Inter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.				or respiratory a	arrest,	Approximate Interval Between Onset and Death
Andre .	Physician		Immediate Cause (Final disease or condition resulting in death)		cell lex	CA			7107-1109
	/Medical Examiner		Due to (or as a consequen	nce of):					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	nce of):					
	ecuted and transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence)	non of:					
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_	± 6 €	Medical	IF FEMALE:			8-		Y	30-1
O. Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as:	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	eath 3□	Ectopic pregnancy Other (specify)	<i>y</i>		23d. Date of Month	
o.	uires that the de signed by the d be detached t	by Ph	Part II. Other significant conditions contributing to death but not resulting	ng in the und	derlying cause give	en in Part I.			ute to the cause of death? ☐ Probably 4 ▶ Unknown
Sor	w requir been si should I	eted					24a. Was	s an 24b. We	re autopsy findings available
Division of Vital Records,		Completed					auto	opsy prid	or to completion of cause of ath? Yes 2 No
Vita V	ician: The certificate h rector, page	Be	25. Was case referred to medical examiner? Hospital:		Othe	26. Place of Dea			/O
ō	ding Phys h. After this funeral dii	n: 7	27. Manner eath 28a. Date of Injury 20	8b. Time of Injury	28c. Injury	y at		how injury occurred	(Specify)HOSPICE
ion	tending leath. tor: Aft the fun	atio	2 Accident investigation		M 1 □	Yes 2 □ No			
DIVIS	pital or Atten- burs after deat eral Director: filled in by the	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of !njury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location City or To	(Street and Number own, State)	or Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge one) 29 Medical Examiner: On the basis of examination and manner stated.	edge, death on and/or inv	occurred at the tire vestigation, in my o	me, date and place opinion, death occu	e, and due to the irred at the time	e cause(s) and mani e, date and place, an	ner as stated. d due to the cause(s)
	To the Hos within 24 hd To the Fun completely	Me	29b. Signature and fittle of certifier		29c. Licens	e number		29d. Date signed (Month, Day, Year)
			Wohat & Kice MD, PAN)	000	06459	「ナー」	117/	09
	1141		70. Name and address of person who completed cause of death (Item 2	3a) (Type, P	Ca ter	Street 1	, Kist	ui star k	D 21157
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signatur	re)		-11000	العبي	. 11000	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	Regist	rar	laking nonna	8 1	1.11				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-00232 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** JANUARY 5. 2009 11:35P BEATRICE POSNER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** GILCHRIST HOSPICE CARE TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 08/06/1917 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours 1 □ M 2 🕡 F 91 Director 220-05-3871 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exertings must be notified at 1 ☐ Yes 2**Y**☐ No Director MD BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21209 USA 1B FRIENDSWOOD COURT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ∐Yes 2√ No Yes Give 1 ☐ Never Married 2 ☐ Married 1 □Yes 2√□No Specify: 2 Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) WHITE COFFEE POT 12 MANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **ABRAHAM TAMRES** IDA FRANKLE ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ages 1 and 2 nt of Health a 1B FRIENDSWOOD COURT BALTIMORE, MD 21209 ALLAN POSNER / SON 20b. Place of Disposition (Name of Complete Cematory or other place)
ANSHE EMUNAH
AITZ-CHAIM CONG. 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify), permit. Pag Department Important: If any injury or 01/07/2009 BALTIMORE, MD of Funeral Service License 22. Name and Address of Facility 21. Sig SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE. 21208 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final oms Physician disease or condition resulting in death) /Medical Dons Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner transit and Due to (or as a consequence of) burial-t attending physician Physician/Medical the as IF FEMALE: nse ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy for Month 5 Other (specify) ned by the a 9 Unknown 9 Unknow signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No this certificate 1 ☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Deer (Specify) WOSPICE 2 🗆 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural Injury 5 Pendina January 2 2009 UNWITNESSED Full From Red. 1 Yes 0945 Accident 3 Suicide investigation al or Attend after death. completely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 4730 ATRIVM COVET, ONINGS MILLS MD home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

P.O. Box 68760. certificate be Division of Vital Records.

Baltimore, Maryland 21215-0036

2 should be fi and Mental h

To the Hospital within 24 hours a To the Funeral C

death.

State Registrar 31. Date filed (Month, Day, Year) JAN 08 2009

MANON

32. Pégistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

S

6201 N. Cherks

29c. License number

MNDSMOT

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

TOVALIO TRIORE		For State egistrar	Certificate of		Reg	No. 200	9 0023
Physicia Medical Examir	n/	. Decedent's Name (First, Middle,Last)	e Ricks	1 60	2. Date of Death Month January 4, 2	Tay Year	3. Time of Death 2036 hrs
*		a. Facility Name (if not institution, give street and		. City, Town, or Location of Dea		4c. County of Death	Λ
		Johns Hopkins Hospital 5. Social Security Number 6. Sex	7. Age (In yrs: last birthday)	Baltimore If Under 1 Year If Under 24h	Irs · 8 Date of Birth	(MM/DD/YYYY) 9. Birth	place (State or Foreign
Funeral Director	4	791-80-3773 1 M 2	11		in. Mar. 27	Cour	ew York
id how any re-	Ţ	Maryland 10b. County	10c. City, Town or Locatio	Baltimore	-		10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Funeral Director	10e. Street and Number 3689 Phydrie Ave.	Apt D5	10f. Zip Code 21239	100	. Citizen of What Count	ry?
15-0036 filed within 72 hours after death with the Maryland I Hygiene. d other than "natural", or items 23a or 28a-f she i, the Medical Examiner must be notified at once	Funeral		ed Forces? If Yes	Decedent of Hispanic Origin? (s, specify Cuban, Mexican, Pue		14. Race - Americ White, etc.	an Indian, Black,
urs aft	a P	15. Decedent's Education (Specify only highest	grade completed) 16a. Decedent's	S Usual Occupation (Give kind o		16b. Kind of Business/In	dustry
215-0036 De filed within 72 ho nal Hygiene. Red other than "usent, the Medical Ex	Completed	Elementary/Secondary (0-12) College	ge (1-4 or 5+)	st of working life. DO NOT use r Student		NA	^
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	7. Father's Name (First, Middle, Last) Kevin Dozier			me (First, Middle, Ma		46.5
212 ould be d Menta s mark			mother 19b. Mailing	Address (Street and Number of	or Rural Route Numb		1 1 1
e, MD 21215-C I and 2 should be filed v Health and Mental Hygi item 27 is marked oth		19a. Informant's Name/Relationship (Type, Print Francis Fraziér - Dozlér 20a. Method of Disposition	20b. Place of Disposit	Purdue AV ion (Name of cemetery,		20c. Location - City or T	1 1 1
		1 Burial 2 Cremation 3 Remov			13/09	Battimore,	Maryland
Baltimore, permit Pages Lar Department of Hee Important: If ite		Donation 5 Other Specify: 21. Signature of Funeral Service Lios Tipes AM A A A A A A A A A A A A		me and Address Facility	Ker Fun	eral Home 1	A 71229
Physician Mi.⊐I		23a. Part I. Enter the disease, or complications the failure. List only one cause on each line.		e mode of dying, such as cardia	c or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
xaminer	Ì	and the second s	as a consequence of):				
	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or	as a consequence of):	100			
7	Examine	cause. Enter Underlying Cause (Disease or injury that initiated	as a consequence of):				
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1876 rtificate ing phy as the t	M/ug	2h Miss decedent prognant in the	yes, outcome of pregnancy live birth 2 Feta	al death 3 Ectopic pre	gnancy	23d. Date of delivery Month D	ay Year
Box 687 e death certific the attending ted for use as the	/sician/	4 Vac 2 No 0 Helenus 4 P	Pregnant at time of death 5 Oth	er (Specify)			93
O. E nat the d at the d by the etached	y Phy	Part II. Other significant conditions contributi	ing to death but not resulting in the ur	nderlying cause given in Part I.		pacco use contribute to t	
S, P, I puires the signer of t	ted by				_ 1Yes 24a. Was a	2 No 3 Prob	opsy findings available
Cord	Completed				autops perforr	y prior to coned? death?	ompletion of cause of
Rentificate or, pag		25. Was case referred to medical		26.Place of Death (Che	1 Yes 2	No 1 ✓ Ye	s 2 No
Vita hysicia this cel	To Be	examiner? 1 ✓ Yes 2 No	Inpatient 2 ER/Outpatient			Residence 6 Other	
on of anding Plath.		1 Natural 5 Pending Jan	Date of Injury Month Day Year) 4, 2009 28b. Time of In	jury 28c. Injury at Work? 1 Yes 2 ✓ No	28d. Describe hi Subject shot	ow injury occurred	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the start death. **I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaced.	Certification:	Suicide Could not be	Place of Injury - At home, farm, stree	t, factory, office building, etc.	or Town, St	treet and Number or Rur ate) ven Blvd, Baltimore, M	
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the	Medical Ce	29a. Certifying Physician: To the (Check only one) Medical Examiner: On the base of the control of the base of the control on the base of the control of the base of the control of the base of the control of the base of the control of the control of the base of the control of	e best of my knowledge, death occurr asis of examination and/or investigati	ed at the time, date and place, a	and due to the cause	(s) and manner as state	d.
To 1	Med	and man	ner stated.	29c. License number		29d. Date signed (Mor	
		pul h	mi	O.C.M.E.		January 5, 2009	
	ļ	30. Name and address of person who completed Russell Alexander MD		Penn Street, Baltimore.	MD 21201		
l. St	ate		2 Registrar's Signature	Kad			
Regist	rar	JAN 0 0 2000 /		_		OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death Month **Physician** 10:17 P M Jan. 5, 2009 Robert Rudy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 235 Carroll Rd. Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☑ M 2 ☐ F Director 216 36 4359 Nov. 17, 1940 68 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Glen Burnie Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 21060 United States 235 Carroll Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Nockey Rudy Miriam Koch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Joan Rudy / Wife 235 Carroll Rd.; Glen Burnie, 21060 permit. Pages 1 and Department of Heald Important: If Item 2 any Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State JANUARY 8. 1 ☑ Buffial 2 ☐ Cremation 3 ☐ Removal from State GLEN HAVEN MEM. PK. 4 □ Donation & □ Other (Specify) 2009 GLEN BURNIE, MARYLAND 21. Signat re of Furit, al Ser 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy. SE; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final disease or condition resulting in death) Concer **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۵ 1 Nes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe page certificate 1□ Yes Division or Vital 2 1000 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 😾 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ို 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Certification: Hospital or Attending Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300 | S. Hanover St. Battimere Hanover

Ruemo

(Check only one)

29b. Signature and title of certifier

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

Jan, 06, 2009

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes a a a

		•	For State Registrar		State	Of Waryie	ind / D	Certifi	cate of	Death	ina mon		eg. No.	009	UUZ))
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	/Medic	al .	J. Stanle	*	aive street and	number)		4h	City, Town, o	or Location of		nuar	1 4c. Co	2009 Junty of Death	2009	IVI
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	Funeral Director		5. Social Security N 203-10-893		6. Sex 1 X M 2 □ F	7. Age (In y			Inder 1 Year nths Days	If Under 2 Hours	24 Hrs. 8. D. Min. 11	ate <i>o</i> f Birth <i>Aonth, Day,</i> /25/191	16	9. Birthp Coul Pennsy	olace (State or Fo ntry) /Ivania	reign
	and		Usual Residence o	f Decedent 10b. County		10c.	City, Town	or Locatio	n						10d. Inside City Li	imits
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Rotz $Stan/eY$ Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical once.	To Be C	17. Father's Name		ast)					18. Mother	r's Name <i>(Firs</i>	st, Middle, I	Maiden Su	ırname)		
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3alti	permit. Pag Department Important: I any injury c		21. Signature of F	. 6	icensee	G ₁			me and Addre			rd J.		Inc.		
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ر. ح	s that t ined by e detac	y Ph	Part II. Other sign	nificant conditio	ns contributing t	o death but not	resulting in	n the under	lying cause gi	iven in Part I.		23e. Did to	bacco use	contribute to	the cause of deat	
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	ne Hospit n 24 hours ne Funera pletely fille	Medical (29a. Certifier (Check only one)	Certifying 2 Medical f	g Physician: To Examiner: On the and r	the best of my ne basis of exar nanner stated.	knowledge nination an	e, death <i>o</i> c nd/or invest	curred at the igation, in my	time, date an	nd place, and o ath occurred a	due to the o	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)	
	To the withing the confidence of the confidence	Z	29b. Signature ar	end title of certifier	(2)	(M.	D:		29c. Licen	133				Signed (Month	Day, Year)	
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DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene 2009 00236 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Robert Physician Schmidt Month 0925PM 2009 January 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital N/A **Baltimore City** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 28, 1 Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F Days Hours Min 219-40-8371 65 Yrs. Director 1943 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Marvland N/A Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 1104 Quantril Way 21205 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 2 X No 1 ☐ Never Married 2 🎇 Married 1 ☐ Yes 2 🗓 No Specify \$ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. PO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Baker Bakery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Schmidt Eleanor McCovin ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laverne_Schmidt, Wife 1104 Quantril Way Baltimore, Maryland 21205 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

Cremation
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290 Frederick Baltimore, Maryland Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Approximate Interval Between Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Attending Physician: The law requires that the death certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) detached the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has 1 Tyes 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury death. 1 Yes 2 No s after death filled in by the 3 🗌 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò within 24 hours To the Hospital 29a. Certifier 1 Xcertifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Stauna Pelomin RES-000 January 07 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Joanna Peloquin

JAN 0 8 2009

31. Date filed (Month,

32 Registrar's Signatur

600 North Wolfe St, Baltimore, MD, 21287

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			For State Registrar		State of Ma	arylan				lealth and <i>Death</i>	Me	ntal Hy	giene Reg. No		9	00237
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ز	Examin	er	4a. Facility Name (I	f not institution, give	street and number)			B	altin	r Location of Dea				. County of De		
	Funeral Director		5. Social Security N 217-14- Usual Residence of	9711 ¹⁰	XM 3□E	e (In yrs. I 89	ast birthday) Yrs.	If Unc Month		If Under 24 Hr Hours Mir		Date of Bi (Month, D)8/21			irthplace Country) ryla	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Rooseveit Lee Scott Jr. Year 8:55 PM anvan /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Seasons Hospice Randallstown Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) /-12-1959 Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F Months Days Hours Min 220-78-6405 Director 49 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10h County 10c. City, Town or Location ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Marical Experience 1, ust be notified at 10d. Inside City Limits 1 □Yes 2 No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7150 N. Alter Street 21207 USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 □ Yes 2 □ No
If Yes, Give
Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: African-American <u>چ</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, The M Machine Helizer Abell Plastic Inc. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roosevelt L. Scott Sr. DeReatha West ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Damon R. Scott/Brother 7150 N. Alter Street, Baltimore, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 1-9-09 Woodlawn, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wile Fineral Home P.A. of Balto. Co. rand ON 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory
Due to (or sa consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Year Month Day 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐Yes 2 No 2 **N**O funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 🗍 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 □ No after death Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deborah I Birton 2835 Smith Avenue Suite 203 Baltimore MD 21209 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 03.26 AM AHUARY 6 2009 Streets /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glen Burnie, Mid Arme Hrunde Baltimore Washington Wedical If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 🖾 F 216-03-5703 April 28,1916 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Anne Arundel Millersville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8286 Pond Court 21108 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 21 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: Specify: White þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 6 Inspector Western Electric Department of Health and Mental Hy Important: If Item 27 Is marked othe any injury or other trees. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Dominic Kaszubinski Lottie Pawloski ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MS. Lucy Whittemore /Sister 8286 Pond Court Millersville MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Jan. 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vets. Cem. Crownsville, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services 1 2nd Avenue Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ALZHEIMERS Physician ADYANCED /Medical Due to (or as a consequence of) Examiner 在 PAENSIDA Se uentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) physician and stransit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a d be detached for P.O. I 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 Probably 4 Unknown 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 2 🗆 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**0 Hospital: 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA ٩ filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred After t 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the I 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the I 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20161

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 00240 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 Day **Physician** AUNDERS KOBER, 128 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Sex MCNTGOMER

9. Birthplace (State or Foreign
Country) 10 24 Hrs Min. Age (In yrs. last birthday) 8 Date of Birth (Month, Day, **Funeral** Year) Days 1 M 2 □ F Months Hours 250-38-976 Usual Residence of Decedent NORTH CAROLIN Director filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating must be notified. 10a. State 10b. County 1 KYes 2 No WAShINGTO Director 10g. Citizen of What Country? 10e. Street and Number USH Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7114157 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAUNDER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) ROTH 206. Place of Disposition (Name of cemetery, crematory or other plage) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 110/09 LEHN WOOD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licen 10220 Guil Ford Ra UE Part From Heart Sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BILATERA **Physician** WILS /Medical Due to (or as a consequence of) Examiner RE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed signed by the attending physician and it be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 2 1 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law requir within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should I Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 XNo 2 □ No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORA 31. Date filed (Month, Day, Year) 32. Registrar's S State JAN 0 8 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death SYLVIA GERTRUDE **Physician** 7.35 PM JANUARY 2009 05 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOSPITAL HARBOR BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 22,1955 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F Months Days Hours 212-70-2892 Yrs 53 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
Instit if Item 27 Is marked other than "natural", or iteme 23s or 28s-f show any or other transmic event, Ite Medical Exercities instituted at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21060 1022 Roseanne Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗓 No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Marie Brown Henry Poynot ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1022 Roseanne Road Glen Burnie, MD 21060 Mr James Sylvia Sr./Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jan. 10, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: ff any injury or once. 2009 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park Glen Burnie, MD 21. Stunature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services 1 2 ND Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANOXIC ENCEPHALOPATHY Physician SEVEN DAYS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🙀 No Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. P the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ cete has been signi, page 2 should be Be Completed 1 Tes 2 No 3 Probably 4 WUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy performed? 2 X No 1 ☐ Yes 2 🔼 No After this certification 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 🔯 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RE5001 JANUARY 05 2009 1 lemman hiran, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHIRANI 3001 SOUTH HANGVER STREET BALTIMORE MARYLAND 21225 PEYM AN 31. Date filed (Month, Day, Year) . Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mar	yland	-	rtment of F tificate of i				ene g. No. 20 (19	002	142
	Physici	an	1. Decedent's Name (First, Middle, La	•					2.	Date of Death Month	Day	(ear	3. Time of D	
No.	/Medic	al	William C. Saur, 4a. Facility Name (If not institution, given				4b. City, Town, or	Location of	of Death	01-	06 - C	Death	5ido	<u>а</u> м
7	Exami	e.	Franklin Square	1/25 pita/Cer	nter		ROS	edale			Ba1	timo		
-	Funeral Director		5. Social Security Number 6. \$ 218–09–5241	Sex 7. Age (1 1 1	(In yrs. las	t birthday) _ Yrs.	Months Days	If Under Hours	Min. JL	Date of Birth (Month, Day, Ine 24, 1	918 °). Birthp Coun Mary	lace (State or htry) /Iand	Foreign
	and w		Usual Residence of Decedent 10a, State 10b, County	1	0c, City, 1	Town or Loca	ation			,		1,	0d. Inside City	/ Limits
	a-f sho	ctor	Maryland N/A			Baltim							1XXYes	2 □ No
	should be filed within 72 hours after death with the Maryland and Merital Hyglene. s marked other than "natural", or items 23a or 28a-f show umatic event, if a Midfiel Exemples must be notified at	Director	10e. Street and Number 3548 Chesterfield Av	enue			10f. Zip Code	213		10	g. Citizen of Wh	at Coun	try?	
	ems 23	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. W	as Decedent of H Yes, specify Cuba	ispanic Ori	igin? (Specif	y Yes or No-	14. Race	- America White, e		
36	within 72 hours after dea iene. than "natural", or items he Medical Examinar m	by F.	1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	1 □Yes 2XXNo If Yes, Give Year or Dates:			□Yes 2 No	Specify:		an, 0.0.,	Specify:			
5-0(72 hou 'natura dicel E		15. Decedent's E (Specify only highest gr	ducation		(Give ki	ent's Usual Occup	during mos	t of working	1	6b. Kind of Busi	ness/Ind	lustry	
2121	within jiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Forem	O NOT use retired an	1)			Shipyar	d		
$S_{a}^{\prime} $	should be filed within 72 hou nd Mental Hygiene. marked other than "natura imatic event, the Medical E	Be	17. Father's Name (First, Middle, Last)				_		irst, Middle, M	aiden Surname)			
ıryla	d 2 should the and Men 7 Is marke traumatic	မ	Christian Saur 19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing	Address (Street		Maurer er or Rural F	loute Number.	City or Town. S.	tate. Zip	Code)	
2. Σ Σ Σ	S = 6	13	William C. Saur, Jr./	Son		13224	Dulaney Va		Road Gl	en Arm,	Maryland	2105	57	
	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other to		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	cem	netery, cřema	tion (Name of atory or other plac vice Corp.	:e)	1/8/09		oc. Location - C Towson Ma	•		
altir	permit. P Departme Importan any Injur	1	21. Signature of Funeral Service Lice		112.2.2		Name and Addre						iu.	
	8 9 E E 9		23a. Part 1. Enter the disease, or com	plications that several th	o dooth	- 1						14	Approximato	
9	Physician /Medical Examiner the private percented the private that the pri	al Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any team of the Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c	29 / S romequer	nce of):	neumon	ia					Approximate Interval Betw Onset and De	een eath
. Box 6	death certif e attending d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal de	eath 3 🔲	Ectopic pregnanc Other (specify)	у			23d. Date Mont		-	∍ar
ds, I	The law requires that the ate has been signed by th age 2 should be detache	ρ	Part II. Other significant conditions of Seren	_	not resultir	ng in the unc	lerlying cause give	en in Part I.			acco use contrib s 2 ☐ No 3			
cor	aw requisite been 2 should	Completed								24a. Was an			osy findings av	
a R	sician: The law certificate has b irector, page 2 sl	Com								autopsy perform 1 □ Yes 2	ed? 💄 de	or to con ath?]Yes		JSE OT
Vit	Physician: this certifica al director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2∏ FB	?/Outpatient	3□ DOA Oth	OF:		Check only one) nce 6 □Other	(Cassifi	d)	
in of	nding Physician: th. : After this certifica ? funeral director, p	on:T	27. Mann of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Y	28	Bb. Time of Injury	28c. Injur Work	y at </td <td>280</td> <td></td> <td>v injury occurred</td> <td>· · · · · · · ·</td> <td><u>//</u></td> <td></td>	280		v injury occurred	· · · · · · · ·	<u>//</u>	
Division of Vital Records,	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Certification: To	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e Oos Blace of Injury	- At home	e, farm, stree		Yes 2□		Location (Stre	eet and Number	o <i>r Rur</i> a	l Route Numb	er,
	pital or ours afte eral Dir filled in			nysician: To the best of				mo data ar	ad place and				batad	
	he Hos in 24 ho he Fun pletely	Medical	(Check only 2 Medical Example)	miner: On the basis of exand manner state	xamination	n and/or inve	estigation, in my o	pinion, dea	ath occurred	at the time, da	te and place, an	d due to	the cause(s)	
	Vith Com	Σ	29b. Signature and title of certifler				29c. Licens	e number	۸۸	29	d. Date signed (Month, E	Day, Year)	
			30. Name and address of person who	completed cause of dear	th (Item 2	3a) (Type, P	rint)	0000			16/09		221	
	D Sta	te.	Dr. Maryam 30 31. Date filed (Month, Day, Year)	32 Registrar's	Fra Signature	an/Clin	Square	Dri	Ve Bo	1 /1/ma	re Md.	212	34	
	Registr		JAN 0 8 200		A.	bar	les!							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 30 per dyr 9887 1-8-09 yr
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 200 January /Medical 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Yea April 15, Birthplace (State or Foreign Country) **Funeral** Year) Days Months Hours 1**x** M 2□ F 88 1921 Maryland 218-09-4354 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County show at a or 28a-f sho be notified a 1 ☐ Yes 2 ▼ No Director Maryland Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 6001 Windsor Mill Road 21207 USA ral", or items 23a Examiner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WW II 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 'natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Pages 1 and 2 should be filed went of Health and Mental Hygier nt: If Item 27 Is marked other thy or other traumatic event, the Self Employed Vending 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Barton Sparklin Lu1a 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris E. Sparklin (Wife) 6001 Windsor Mill Rd., Baltimore, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ott 1 Burial 2 □ Cremation 3 □ Removal from State Oak Lawn Cemetery 1/7/09 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Error Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran and Due to (or as a consequence of) Box 68760 attending physician pe Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month ρ Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the aid be detached f P.O. 9∏Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ş 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an page 2 has certificate 1∐ Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA funeral dir 2 After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation or Attending 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2095 Mt. Smith Hebron Dr. Ellicott City, Md. 21042 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1 Decedent's Name (First Middle, Last) 2. Date of Death Smith Andrew Kenneth p M 3:09 2009 January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 1234 Elmridge Avenue Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth
July 30, Year) 947 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 1 ₽ M 2 □ F Mary Tand 61 214-46-1082 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Baltimore **Baltimore** 10e. Street and Number 10f Zin Code 10g, Citizen of What Country? USA 1234 Elmridge Avenue 21229 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Plumber State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Soloman Smith Gladys Ellen Golliday Kenneth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1234 Elmridge Ave., Baltimore, MD 21229 Sarah M. Smith (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 1/6/09 Baltimore. Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityLoudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐Yes 2 ☑No 1 ☐ Yes 2 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Examiner or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 death.

and buriat-trar attending physician for use as the buria the the been signed by pe director, page 2 should has this certificate funeral After t the within 24 hours after death To the Funeral Director: filled in by Hospital completely

Physician

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the World's Exercitor in the notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "any Injury or other traumatic event, It was any Injury or other traumatic event, It was

Physician

/Medical

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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Funeral

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Certification: To

Medical

29a. Certifier

(Check only one)

29b. Signature and title of pertifier

Registrar

DHMH 17 Rev 1/2001

MAIDEN CHOICE (N, CATENSVICE M) 2/228 GARG MS 716 32. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

09-00011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Type of Fillit in Dia	CK IIIaciioic		
State of Maryland /	Department of He	ealth and Mental	Hygiene

2009 00245

Vestor Levi reger		For State	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Certificate	of Death			. No.	007 001
Physician		gistrar Decedent's Name (First, Midd	lle,Last)				Date of Death Month	Dav Year	3. Time of Death 0834 hrs
Pnysician Medical Examine			i Tegeler -Zin	merman-		1	January 1,	2009	
		a. Facility Name (if not institution	on, give street and number)		4b. City, Town, or Lo	cation of Death	-91.27	4c. County of I Carroll	Death-
		Carroll Hospital Cente			Westminster		6 B 1 (C B) 40		9. Birthplace (State or
Funeral	. 5	Social Security Number	6. Sex 7. Ag	e (In yrs. last birthday) If Under 1 Year Months Days	If Under 24Hrs. Hours Min.		Į.	oreign
Director	1	nlA	1 XM 2 F		Yrs. 15	110013	12/17	/2008	Country) MD
	L.	Isual Residence of Decedent							10d. Inside City Limits
an X	200	0a. State 10b. County	/	10c. City, Town or Lo	ocation				1 Yes 2 X No
ž .		MD Car	rroll	Westm	inster				
2 9 Maryland 28a-f show d at once.	용는	0e. Street and Number			10f. Zip Code		10	g. Citizen of Wha	it Country?
ied 2	Director	908 01d West	minster Pike		2115	57		USA	
		1. Marital Status	12. Was Deceden		. Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Spe	ecify Yes or No-	14. Race - White,	American Indian, Black, etc.
ath w	Funeral	and the same of th	Married Armed Forces	? 2 X No	If Yes, specify Cuban,	Wexicall, Fuelto I	doari, oto.)		
er de		3 Widowed 4 D	ivorced If Yes, Give Year	1	Yes 2X No			Specify:	White
hours after 'natural'', Examiner	<u></u>	15. Decedent's Education (Sp	pecify only highest grade co	mpleted) 16a. Dec	edent's Usual Occupation	on (Give kind of wo	ork done ed)	16b. Kind of Bus	iness/industry
2 hot	Completed	Elementary/Secondary (0-12					,	. ,	
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15-0036 filed within 77 Hygiene. d other than , the Medical	8	17. Father's Name (First, Midd	le, Last)			8.Mother's Name			
215 be file ntal H rked c	e	Berry Christ	opher Zimmer	man	failing Address (Street	Christin	a Franc	es Tegel	er State Zin Code
21.	은	19a. Informant's Name/Relatio	nship (Type, Print)	1					
MD and 2 sho afth and 2 sho and 2 sho afth and afth and and a sho a sho and a sho a sho and a sho and a sho and a sho and a sho a sho a sho a sho a sho a sh		Chris Zimmer	man/Father	90	8 Old West	ninster .	Pike, W Date	estminst 120c Location -	city or Town, State
Heaft		20a. Method of Disposition		crematory	isposition (Name of cen or other place)				
nt of it. If other		1 X Burial 2 Cremat		Meadow	Branch Cem				inster, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Hea(th and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		4 Denation 5 Other 21. Signature of Funeral Servi	Specify: ice Licensee		22Burrand Address	deelity Fun	eral Ho	me & Cre	ematory, P.A.
Ba Perm Depa Imp		A Generalla	101110		1212 W. O	ld Liber	ty Rd.,	Winfiel	Ld, MD 21784
Physician	-	23a. Pary I. Enter the disease,	or complications that cause	ed the death. Do not e	nter the mode of dying,	such as cardiac o	r respiratory ari	rest, snock, or nea	Between Onset and
Medical		failure. List only one cau	ase a. Sudden	unexplaine	ed death in	infancy	(SUDI)		Death
aminer		Immediate Cause (Final disea or condition resulting in death	Due to (or as a con	nsequence of):					
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	Je.	if any, leading to immediate cause. Enter Underlying Cau	Due to (or as a co	nsequence of):					
	Examine	(Disease or injury that initiate	Due to (or os a so	nsequence of):					
ecuted and transit	Ĕ	events resulting in death) La	isi				-/ - 	11011	
60, rate be executed physician and ne burial - trans	g	XUNPENDED	X AMENDED #	1, 23a, 2/,	28a-f,perME	, 6892 0	0/13/09	TT	
'60, cate be ex physician he burial	Medical	IF FEMALE:		come of pregnancy				23d. Date o	
876(ifficate ng phy		23b. Was decedent pregnant			Fetal death 3	Ectopic pregna	ancy	Month	Day Year
, P.O. Box 687 ires that the death certific signed by the attending. It be detached for use as it be detached for use as it.	sician	past 12 months?	7	t at time of death 5	Other (Specify)			II.	
Bo deat	Phys	1 Yes 2 No 9			in the underlying cause	given in Part I	23e. Did	tobacco use cont	ribute to the cause of death?
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ion of Vital Records, P.O. Box 687 tending Physician: The law requires that the death certific for: After this certificate has been signed by the attending Ir the funeral director, page 2 should be detached for use as the	d by						24a. Wa	s an 24b.	Were autopsy findings available
ords, w requir s been s should	Completed						aute	opsy formed?	prior to completion of cause of death?
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Division of Vital Records, tal or Attending Physician: The law requir and after death. The Director: After this certificate has been steen by the funeral director, page 2 should I led in by the funeral director, page 2 should I		25. Was case referred to me	edical		26.Plac	e of Death (Check	k only one)		
ital iician s cert irecto	Be	examiner?		patient 2 🗸 ER/Ou	tpatient 3 DOA	Other ₄ Nurs	ing Home 5	Residence 6	Other:
fV Phys er thi	2	1 Yes 2 No 27. Manner of Death	28a. Date of			ury at Work?		e how injury occu	rred
n of ding Ph ding Ph h.	6	1 Natural 5	Pending F.A. 1 /		7:47 am 1	Yes 2X No	unk		
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Divisipinal privity pital or At ours after decrated Direct filled in by	ertification:	3 Suicide 6 X	Could not be determined (Specify)	residenc	ce		Pike _	Westmins	ster, MD
	0	29a Certifier		of my knowledge, dea	th occurred at the time,	date and place, ar	nd due to the ca	ause(s) and mann	er as stated.
Fo the Hos within 24 h Fo the Fin	ical	(Check only one) 2 Medical	I Examiner: On the basis of	examination and/or in	vestigation, in my opinio	on, death occurred	d at the time, da	ate and place, and	i due to the cause(s)
To the withing to the complex	Medical	29b. Signature and title of c	and manner sta	ited.		nse number		29d. Date sig	gned (Month, Day, Year)
	2		11 11 1		0.0	C.M.E.	OCME	January 2	2, 2009
-	1	Theodore	W. KT&I	A mod					
		30. Name and address of portion of the odore M. King	erson who completed cause	nt Medical Exam	iner 111 Penn S	Street, Baltimo	ore, MD 212	201	
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Regis	Stat Stra			in B. A	early				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician ODFREY Thomasy 7:35 P M 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore NIA City Hospital d If Under 1 Year | If Under 24 His. 5. Social Security Number 6. Sex U 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Months 1 **⊠**M 2 □ F 241-34-7461 APRIL 30,1926 Director N.CARDUNA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylau Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exprainer must be notified at once. 1 XYes 2 No NIA BALTIMORE Director MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BIACK þ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AMERICAN HIRLINES SKYCAP 8TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be THOMAS THOMAS TABITHA DAVID ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3504 WYNETTE SIMS (DAUGHTER) COPLEY RD., BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State DOOD (AWN CEM, 01/12/2009 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Miamo SOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMERE, MD 2121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Status **Physician** Astronoticus LO 1946 /Medical Due to (or as a consequence of) Examiner Chronic destructure Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Por Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☑ No 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No within 24 hours after death.

To the Funeral Director; After this o completely filled in by the funeral dire 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MBBS January, 5, 2009 000 30. Name and address f person who completed cause of death (Item 23a) (Type, Print) MBBS BG, ROW BL Sinai Hospital KIREET

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Thomas, Godfres

as

knew

ORIGINAL

32; Registrar's Signature

Reg. No.

Day

4c. County of Death

USA

HEALTH

14. Race - American Indian

BLACK

Black, White, etc.

BALTIMORE

2. Date of Death

Month

3. Time of Death

5:15 P

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Lomonths

X Yes 2 □ No

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed? (es 2 No 2 No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 01-07-09 9114 PHI LADELPHIA ROAD, MD-21237

State Registrar

31. Date filed (Month, Day, Year)

For State Registrar

1. Decedent's Name (First, Middle, Last)

32. Registrar's Signature

JAN 08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 29d,30 per dvr g887 1-8-09 vt State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** orine 9009 /Medical Januaru 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** aroline ear | If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** -44-937 1 □ M 2 🖫 F Months Days Hours Min. Director 930 24 1938 Aug Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylanc 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Department of Health and Mental Hygiene, important; or Items 23a or 28a-f show important: If item 27 is marked other than "natural"; or Items 23a or 28a-f show important: If item 27 is marked other than a local field at a more than 12 and 1 Director 1 AYes 2 No 10g. Citizen of What Country? 10e. Street and Number 118 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) N USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) hool Crossing Guard School 18. Mother's Name (First, Middle, Maiden Surname) 8 tm Schoo 17. Father's Name (First, Middle, Last) Be ၉ Willie Treen lary Stevenson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Roral Route Number, City or Town, State, Zip Code) Penny 1-20a. Method of Disposition 949 Footman daughter Winder 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1-6-09 Al Essex, MI 270 Fuhilton Pass 4 ☐ Donation 5 ☐ Other (Specify) parden of Faith MD 21. Signature of Funeral Service Licer 22. Name and Address of Facility Balto, mu 21229 Fineral Home P.A larch Jary envo have 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each time. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. The Law Ather after death. The Funeral Director: Attent his certificate has been signed by the attending physician end mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ā</u> 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after

To the Funeral Dire

completely filled in b Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 09 son who completed cause of death (Item 23a) (Type, Print) Md. 21287-0941 601 N. Caroline St. Balto. Rosalyn W. Stewart 31. Date filed (Month, Day, Year) 32. Registrar's Signature State franks Registrar JAN 0 8 Medera.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene								
			1 - State Registrar Certificate of Death	la Bu	Reg. No	2009	00249		
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. +	/Medic Examin		4a. Facility Name (#-not institution, give street and number) 4b. City, Town, or Location of D	Death	40.	. County of Death	1100		
توسر			Mercy Medical Center Baltimore	MD		U.5	. A.		
e.	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 On the second of the	Hrs. 8. Date of (Month)	, Day, Year)	Соц			
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	the M 28a-f	Director	10e. Street and Number 10f. Zip Code		10g. Cit	tizen of What Cou			
	th with 23a or	alD	14 CedAR Hill Rd 21225	5		U.S	A -		
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P	? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ameri Black, White,			
36	be filed within 72 hours after death with the Maryland Hygiene. do other than "natural", or items 23a or 28a-f show event, It a hadical Evaninar must be notified at	þ	1 □ Never Married 2 □ Married 1 □ Yes 2 🗷 No If Yes, Give 1 □ Yes 2 🛣 No Specify: 3 🛣 Widowed 4 □ Divorced Year or Dates:			Specify: Whi	.te		
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Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinat must be notified at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility		_	eral Home			
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	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death, within 24 hours after death, within 24 hours after death, or the Funeral Director. After this certificate has been signed by the attending the completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	occurred at the ti	me, date an	d place, and due t	o the cause(s)		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year WILSON UZANNE 45 AM ELVIRIA JANUARY , 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** BALTIMORE UTURE CARE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Securify Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖫 F 220-30-071 75 MARCH 21,1933 Director MARYLAND Usual Residence of Decedent 10c. City, Town or Location 0d. Inside City Limits 10a. State 10b. County iral", or items 23a or 28a-f shov 1 Yes 2 □ No BALTIMORE Funeral Director MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2121 MONTEBELLO TERRACE Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or items 23. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?, 1 ☐Yes 2 ▼No 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced marked other than "natural matic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) APARTMENT BUILDING RECEPTIONIST 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAMS VERNON JACKSON ANNA Important: If Item 27 Is marke any Injury or other traumatic once. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBORAH ROBINSON (DAUCHTED) 2802 MONTEBELLO TERR., BALTIMORE, MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of It 1 Burial 2 ☐ Cremation 3 ☐ Removal from State KING MEMORIAL PARK O1/09/2009 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 2 Name and Address of Facility
058 PH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE., BALTIMORE, MD 21217 21. Signature of Funeral Service Licensee illeam 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Spiratio Minutes NEUMONIA /Medical Due to (or as a consequence of): Examiner Shaque 59 Sequentially list conditions, than, leading to find edicate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an s certificate has b lirector, page 2 sl autopsy performed 1 □ Yes 2 funeral director, Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 XNatural 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed o 24 hours after death.

e Funeral Director: Af completely

within 2

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

, Reisterstown, MD 21136

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Zibell 31. Date filed (Month, Day, Wear)

Barker

Registrar

	Please	Type or Prin State of Ma			t. Ensure Al Health and M	-	_		
	1 - State Registrar 1. Decedent's Name (First, Middle, L	ast)	Ce	ertificate of	Death	2. Date of Dea		3. Time of Death	
Physician /Medical Examiner	Donald D. W 4a. Facility Name (If not institution, g.		•	4b. City, Town,	or Location of Death	Jan.	7 2009 4c. County of Dea	9:30 A ^M	
Funeral Director	College Man 5. Social Security Number 6.	or Nursing	(In yrs. last birthday	ome Lutherville yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min (Months Days Months Months Months Months Months (Months Months		Baltimore of Birth h, Day, Year) 30 1919 Baltimore 9. Birthplace (State or Foreign Country) Canada			
Maryland -f show	Usual Residence of Decedent 10a. State 10b. County MD Balti	I	10c. City, Town or l					10d. Inside City Limits	
ter death with the Mary ritems 23a or 28a-f st increust be notified increust Director	10e. Street and Number 2204 Eastridge R	d.		10f. Zip Code 210	93		10g. Citizen of What C	country?	
b ii.,	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 □Yes 2 □YN If Yes, Give Year or Dates:	ver in U.S. 13	8. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 🕱 No	Hispanic Origin? (Specian, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)			
ed within 72 hou ygiene. ner than "natura t, rh. "n den E Completed	15. Decedent's E (Specify only highest g	College (1-4or 5+	-) (Giv		during most of workii ad)		16b. Kind of Business	s/Industry	
uld be filed w Mental Hygie arked other t atic event, th	17. Father's Name (First, Middle, Las Morris Will		Mecna	anical En	18. Mother's Name Susanne F	(First, Middle,	Maiden Surname)	a Electric	
and 2 sho eaith and I n 27 is ma ner traums	19a. Informant's Name/Relationship Elizabeth Willia		220	04 Eastri	dge Rd., T	imonium	er, City or Town, State,		
t. Pages 1 rtment of H rtant: If iter ijury or oth	20a. Method of Disposition 1 ☐ Burial ②☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	ify)	Atlantio	position (Name of ematory or other place Cremato	ry 1/9/	09	20c. Location - City o		
permir Depar Impor any ir	21. Signature of Fernial Service Lice M 23a. Part 1. Enter the disease or cor	ichael J. F	lagle]	O W. Pado	neral Hom nia Rd.,	<u>Timoniu</u>	laney Vall m, MD 2109	ey, Inc. 3 Approximate	
Physician Medical Examiner	shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on each line a. Ceven vo Due to (or as a	d Vascular consequence of): Atheros		MF			Interval Between Onset and Death 2 48 hours	
eath certificate be executed attending physician and for use as the burial-transit cian/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):	vtensin					
Physician: The law requires that the death certificate by this certificate has been signed by the attending physic ral director, page 2 should be detached for use as the by: To Be Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3	B ☐ Ectopic pregnan 5 ☐ Other (specify)	су		23d. Date of d Month	elivery Day Year	
law requires that the de as been signed by the 2 should be detached pleased by Physic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to							to the cause of death? Probably 4 ☐ Unknown	
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ysician iis certifi director	25. Was case referred to medical examiner? 1 Yes 2 No No No No No No No								
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page. Medical Certification: To Be Com	27. Manner of Death 1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	ha	y 28b. Time Injury ry - At home, farm, s (Specify)	M 1 E]Yes 2 □No		now injury occurred Street and Number or F vn, State)	Rural Route Number,	
o the Hospital Ithin 24 hours a o the Funeral I ompletely filled	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex-	Physician: To the best of aminer: On the basis of and manner state	examination and/or	ath occurred at the investigation, in my	time, date and place, opinion, death occurr	and due to the red at the time,	cause(s) and manner date and place, and du	as stated. ue to the cause(s)	
To the within To the comple	29b. Signature and title of certifier	~ mo			se number		29d. Date signed (Mor	nth, Day, Year)	
O_f	30. Name and address of person who	o completed cause of de		e, Print)	villion 2	Suite 2	Lutherv 25 210	ille, MD 93	
State Registrar	31. Date filed (Month, Day, Year)	22 Degistra	r's Signature						

DHMH 17 Rev 1/2001

09-00108	
Susan Wiggins	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Susan Wiggins	State of Maryland / Department of Hea 1- For State Registrar Certificate of Dea	th	9. No. 2009 0025
Physician/ Medical Examiner	Susan Wiggins	2. Date of Deat Month January 4,	Day Year
	4a. Facility Name (if not institution, give street and number) 4b. City. Union Hospital Elkto	Town, or Location of Death	- 4c. County of Death Cecil
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Un 2 F 3 6 31 Yrs.	7.4	th(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 24, 1977 Maryland
30 and show any uce.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 Yes 2 No
3430 the Maryland a or 28a-1 show tiffied at once.	10e. Street and Number 10f. Z	2 1 9 0 1	Og. Citizen of What Country?
13436 real", or items 23a or 28a-f sho niner must be notified at once. by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Yes 2 No 1 Widowed 4 Divorced of Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes	dent of Hispanic Origin? (Specify Yes or No- cify Cuban, Mexican, Puerto Rican, etc.) No specify:	14. Race - American Indian, Black, White, etc. Specify: Black
2 hours "natur	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) L2++ College (1-4 or 5+)	Il Occupation (Give kind of work done orking life. DO NOT use retired)	16b. Kind of Business/Industry Manual das Resturant
21215-0036 Juld'be filed within 7 Mental Hygiene. marked other than cevent, the Medica	Reece Sowells	18.Mother's Name (First, Middle, N	7 Taylor
MD 21 d 2 should' lift and Me n 27 is ma umatic ev	Loyce HOPKins - SISTER 820 Blaz	s (Street and Number or Rural Route Num	ober, City or Town, State, Zip Code).
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traun	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Na crematory or other place) 20b. Place of Disposition (Na crematory or other place)		20c. Location - City or Town, State
Balt permit. Departi Import injury	21. Signature of Funeral Service Incensee 22. Name an	d Address of Bacility 270 Red	HILTON Pass Balto, md, 21279
Physician Wedical xaminer	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode failure. List only one cause on each line. Imm—late Cause (Final disease a. Asthma		est, shock, or heart Approximate Interval Between Onset and Death
	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions,	2 6 1	
red nisit	if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that imitated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		
execui an and al - tra	X UNPENDED X AMENDED 23a, PII, 27, permE,	g888 2/4/09 TT	
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be reath. The transport of the transport of the strending physician by the funeral director, page 2 should be detached for use as the burn cation: To Be Completed by Physician/Med	Item#7perFH.G887.1/ IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3 Ectopic pregnancy	23d. Date of delivery Month Day Year
P.O. Bases that the degree by the edetached for by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlyin		bacco use contribute to the cause of death?
Records, P.C. The law requires that freate has been signed , page 2 should be deta	Cardiomegaly	24a. Was a autops	
tal Recuiran: The la certificate huse 2 ctor, page 2	25. Was case referred to medical	perfor 1 ✓ Yes 2 26.Place of Death (Check only one)	
f Vital Physician r this certi ral director	110 2 110	DOA Other Nursing Home 5 1	Residence 6 Other:
Division of Vital Records, spital or Attending Physician: The law requirements after death. Increa Director: After this certificate has been similared in by the funeral director, page 2 should technical or Decentification: To Be Completed	27. Manner of Death 1 X Natural 5 Pending 2 Accident President 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)	1 Yes 2 No	ow injury occurred
Divi	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factor (Specify)	or Town, St	
To the Hospi within 24 hou To the Finner completely file	(Check only one) 2 Medical Examiner: On the bast of my knowledge, death occurred at the one) 2 Medical Examiner: On the basis of examination and/or investigation, in manner stated.		
	Meller Mi	c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) January 5, 2009
	30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn	Street, Baltimore, MD 21201	
State Registrar			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** January 2009 Wesley Yeargain James /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** -On nie Frre Baltimore Washington Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) Funeral Hours Min 1 XM 2 □ F Months Days 69 522-46-1754 Colorado Director July 15, 1939 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinal must be notified at 1 ☐ Yes 2 No Funeral Director Severn <u> Maryland| Anne Arundel</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 7880 Bastille Place 21144 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc and 2 should be filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1958–82 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: Completed by White 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Master Chief Metty Officer US Navy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental tem 27 is marked of Helen Sloan ဥ James Clarence Yeargain 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 21144 7880 Bastille Place Severn, Pauline R. Yeargain/wife Department of Heal Important: If Item 2 any Injury or other once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State West Arundel Crematory 1/7/2009 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road Odenton, Maryland 21113 21. Signa re of Funeral Service Licenses Homas lante Approximate Interval Between Onset and Death 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final C18 **Physician** T. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending pl for use as t IF FEMALE: Records, P.O. Box 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached to 1 ∏Yes 2 ∏No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 1 ☐ Yes 2 No **Division of Vital** or Attending Physician: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Burnia, ms

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

150 m

8 2009

31. Date filed (Month, Day, Year)

JAN O

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Lee Ackerman JANUARY 2009 4:15 PM Carol /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center 4c. County of Death 4b. City, Town, or Location of Death Examiner Towson Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, You Mar. 29, 9. Birthplace (State or Foreign , 1949 Maryland **Funeral** 1 □ M 2 🖵 F 59 218-54-3265 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County il Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Exemprer must be notified at 1 ☐Yes 2X No Bel Air Maryland Harford Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21014 319 Princeton Lane by Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married Maryland 21215-0036 1 □Yes 2√2√No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beauty Supply Customer Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If item 27 is marked o any Injury or other traumatic eve once. Jacquelyn Sprecher ပ George W. Balster, Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 319 Princeton Lane Bel Air, Maryland George Ackerman / Husband altimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan. 8, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Fallston, Maryland HIghview Mem. Garden 4 Donation 5 Other (Specify) 2009 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services—BelAir
3 Newport Drive Forest Hill, Maryland 21050 21. Signature uneral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician CARDIOGENIC SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ACUTE MYOCARDIAL INFARCTION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit RENAL FAILURE ON PERITONEAL DIALYSIS that initiated events resulting in death) Last Due to (or as a consequence of) O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) been signed by the s 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ₽ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performe 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Leath 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

nours after death. neral Director: Af filled in by the fur 24 hours a within 24 hor To the Fune completely fi

FRANK MORRIS, 31. Date filed (Month, Day, Year) JAN 0 9 2009 DHMH 17 Rev 1/2001 ACKERMAN

Registrar

Medical

29a, Certifier

(Check only

29b. Signature and title of certifier

CAROL LETE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

7501

32. Registrar

ORIGINAL

1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DØØ184Ø6

921706

OSLER DRIVE, TOWSON, MARYLAND 21204

29d. Date signed (Month, Day, Year)

			For State Registrar	State of M	Ce	rtificate of			eg. No. 200	9 00256
ķ,	Physicia	an	Decedent's Name (First, Middle,	Last)			Ames	Date of Deat Month	Day Ye	- I M
4	/Medic	al	4a. Facility Name (If not institution,	give street and number			or Location of Death	January	07 2.0 4c. County of D	
	Examin	er	The Jhons Hopkins Ho			Baltimore	city		NA	
22	Funeral Director		5. Social Security Number 216-14-7428	6. Sex 7. Ag	ge (In yrs. last birthday) 92 Yrs.	if Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 3 5	, _{Year)} 9. 1916	Birthplace (State or Foreign Country) VA
	and ww		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryl -f sho fied a	tor	MD	N/A	Baltin	ore				1 X Yes 2 □ No
	th the or 28s e noti	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?
	ath wi		1609 Cliftv			212			USA	merican Indian,
036	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' ed 1 Tyes 2 M If Yes, Give Year or Dates:	No	Was Decedent of Fif Yes, specify Cub 1 Yes 27 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No- o Rican, etc.)		/hite, etc.
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2	Hygid Other ent, tl	Be Co	17. Father's Name (First, Middle, L	.ast)	/ A		18. Mother's Nam	e (First, Middle, I	Maiden Surname)	
/Jan		To B	Andrew John	son			Lilli	e Wyatt	;	
/an	au is	ĺ	19a. Informant's Name/Relationsh						r, City or Town, Stai	te, Zip Code)
	ges 1 and t of Health If item 27 or other tr		Delores Harr 20a. Method of Disposition	is-Niece	20b. Place of Disponentery, cre	osition (Name of	yette S		Balto, 20c. Location - City	MD 21223 or Town, State
Baltimore,			1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		Baltimo	matory or other pla ore Nat	Cem 1-1		Balto,	
alt	permit. Page Department o Important: If any injury or once,	Ì	21. Signature of Funeral Service L		1	2. Name and Addre	ess of Facility M	arch Ea	st F/H	
<u> </u>	B B E B	00 0	1 Dead	up wa	ner					MD 21202
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H	p ±	ner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury		a conse uence of:					
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ď.	w requires that the d been signed by the should be detached	by Pr	Part II. Other significant condition	ns contributing to death	out not resulting in the u	ınderlying cause gi	ven in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
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Vital Records, P.O.		Completed						24a. Was a autops perfor 1∐ Yes	sy prior med? deat	e autopsy findings available to completion of cause of h? Yes 2 [] No
Vita	sician: The certificate ha rector, page	Be	25. Was case referred to medical examiner?	Hospital:		l Ott	nor	th (Check only or		
	ত ভ	- To	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date of Inj	ent 2 ER/Outpatie	W OLI BOX	4 Li Nursing m		ence 6 Other (S	Specify)
lon	Attending Physician: r death. ector: After this certifics by the funeral director, I	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig	(Month, Di ation	ay Year) Injury		rƙ?]Yes 2∐No '			
Division or	al or Atte s after des al Directo ed in by th	Certification:	3 Suicide 6 Could n 4 Homicide determi	200. Place of its	jury - At home, farm, st tc. <i>(Specify)</i>	reet, factory, office		28f. Location (Si City or Town	treet and Number o n, State)	r Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (g Physician: To the bes Examiner: On the basis and manners	of examination and/or in	nvestigation, in my	opinion, death occu			
		N	29b. Signature and title of certifier Www.fm.D			-	-000		•	07,2009
	3		30. Name and address of person of MAIR K. You.	who completed cause of	death (Item 23a) (Type 601 N yrar's Signature	Print) 1. Wolfe	Street	Balto, 1	40 21287	7
	Sta Registr		31. Date filed (Month, Day Year)	2009 Serten	trar's Signature	aled				

DHMH 17 Rev 1/2001

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e Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009	00257
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			State Registrar		,	Cer	tificate of	Death	,	Reg. No.			
	Physicia	200	1. Decedent's Name (First, Middle,	Last)					2. Date of Dea		Year	3. Time of Dea	ath
	/Medic		John W. Agee						January			6:45A	M
	Examin	er	4a. Facility Name (If not institution, g	•				r Location of Death		4c. County			
			Lighthouse Assis		//	46-2	Esse		8. Date of Birt		altin		!
	Funeral Director		5. Social Security Number 6 488-12-3868 Usual Residence of Decedent	Sex 1 M 2 □ F	90	Yrs.	Months Days	Hours Min.	(Month. Da	16,1918		place (State or Fo ntry) SSOURI	nreign
	land ow		10a. State 10b. County		10c. City, Town	n or Loc	ation					10d. Inside City L	
	Mary I-f sh fied s	to	Md. E	alto.		No	ttingham					1 □Yes 2	No
	h the or 28a noti	Director	10e. Street and Number			110	10f. Zip Code			10g. Citizen of V	Vhat Cou	ntry?	
	th wit 23a c		9215 Cornflower	Road				21236	þ	SA			
	ems erm	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. W	as Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)	- 14. Rac	e - Ameri	can Indian, etc.	
₩ge∠ Maryland 21215-0036	2 shoud be filed within 72 hours after death with the Maryland nand Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, I'm Medical Examiner must be notified at	by	1 ☐ Never Married 2 【 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ N If Yes, Give Year or Dates:	Army		□Yes 2 X No	Specify:		Specify	7.71	nite	
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d 2	filed Hygi sther	a)	17. Father's Name (First, Middle, La	st)	Ket	. II e	ı sgı.	18. Mother's Nam	e (First, Middle,			.ary	
al 🛴	d be ental ked c	To B	Oliver D. Agee					Eva Perk	ins				
Haek	shou nd M mar	F :	19a. Informant's Name/Relationship	(Type. Print)	19b	. Mailing	Address (Street	and Number or Ru	ral Route Numbe	er, City or Town,	State, Zi	Code)	
	1 and 2 Health a em 27 is		Joseph Jason	S-1	I-L 82	204	Berryfie	1d Drive	Nottin	gham, Mo	1, 21	1236	
Z o	es 1 a of He fiter		20a. Method of Disposition 11 ☑ Burial 2 ☐ Cremation 3	□ B 0t-t-	20b. Place of cemeter	f Dispos ry, crem	ition (Name of atory or other place	ce)	Date	20c. Location -	City or To	own, State	
enn altimore,	Pages ment of I ant: If its ury or o		4 Donation 5 Other (Spe		Dulane			1-8-2		Timoniur			
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	nsit 7	m in	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			,-		•					
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89	± 5, 6	Medical	IF FEMALE:							1	100		
Box	leath certific attending p		23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	of pregnancy 2 Fetal death	3 □	Ectopic pregnance	CV .			te of deliv		
0.	ie dez the af	hysician	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 🗆	Other (specify)			IVIO	nth	Day Yea	
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	the ithin 2 the make make make make make make make mak	Med	29b. Signature and title of certifier	and manner sta	iea.		29c. Licens	se number		29d. Date signed	d (Month.	Day, Year)	
	F > F 8) (hul	572-	M	0		06190		110	10	2	
	1		30. Name and address of person wh	no completed cause of de	eath (Item 23a)	(Type P	win#\				, , ,	<i>1</i>	
	9		A 1 4		ا ر ی	121	+ Mace	tve no	u, B	actim	OK	MD 2	22
	Sta Registr		31. Date filed (Month, Day, Year) JAN 09		ir Signature	A	and						

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			for State Registrar	State of Mai	ryland / D	epartifica Certifica	ite of L	eaim and i Death	nemai riy	Reg. No.	009	00	258
H	Physicia		1. Decedent's Name (First, Middle, Las	•					2. Date of De	ath Day	Year	3. Time of [Death P M
	/Medic		Malak Hajir Afsh				-	1	January (unty of Death	4:40	
)	Examin	er	4a. Facility Name (If not institution, giver Montgomery Hospic		1150		y, lown, or ckvill	Location of Death			tgomer,	7	
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birth		er 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		-	place (State or	r Foreign
	Director		229-21-3324	21–3324							Iran		
	land Dw		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location			-		1	0d. Inside Cit	y Limits
	Mary I-f sho fied a	tor	Maryland Montgom	erv	Potoma	a C						1 🗌 Yes	2 X No
	h the	irec	10e. Street and Number	<u></u>	2 0 00		Zip Code			10g. Citizen	of What Cour	ntry?	
	ath wii	ral	11812 Seven Locks				2085				State		
0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Important: If tien 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Madical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	ver in U.S.	l		spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		Race - Americ Black, White, ecify: Whi	etc.	
2	72 hc	letec	15. Decedent's Ed (Specify only highest gra	lucation ide completed)	16a.	Decedent's Us (Give kind of v	sual Occupa vork done d	ation luring most of work)	ing	16b. Kind o	of Business/In	dustry	
7	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+))			, e Assista		Feder	ral Gov	ernmen	ıt
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yland	uld be Menta arked artic ev	To B	Mohammad Hajir					Ezatsada	t Emadi				
, Mar	and 2 sho salth and 1 27 is me er traums		19a. Informant's Name/Relationship (Sorahi Azarbarzin		10	906 Bel	lls Ri	and Number or Ru idge Driv	e Poto	mac, N			54
baltimore,	Pages 1 ament of He ant: If item ury or oth		20a. Method of Disposition 1 ☐ Burial 2 🌣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		20b. Place of cemetery Montgoine			, Inc. Januar	J		•	aryland	
Dall	Departit Departit Imports any Inji		21. Signature of Funeral Service Ocea	//	01530	22. Name Rockv Rockv	and Addres ille, ille,	is of Facility Rob Inc. 30 Maryland	ert A 0 West 20850	Pumph: Montgo	rey Fur	eral H Venue	ome/
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused to one cause on each line	the death. Do n	ot enter the m	ode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Bety Onset and D	veen
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C. 20X	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome o 1 Live birth 2 4 Pregnant at t 9 Unknown	Fetal death	3 ☐ Ectopie 5 ☐ Other		/		23d	. Date of deliv Month	-	ear/
	that the poly detact	y Ph	Part II. Other significant conditions	contributing to death but	t not resulting in	the underlying	g cause give	en in Part I.	23e. Did t	obacco use	contribute to t	he cause of de	eath?
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5	Phys r this ral dir	2:	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	nt 2 ER/Out y 28b. T	ime of	28c. Injur	y at	ome 5 ☐ Resi 28d. Describe	_		Mospic	se
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DIVISION	al or Atte s after des il Director ed in by th	Certification;	3 Suicide 6 Could not b 4 Homicide determined		ry - At home, far (Specify)	m, street, fact	ory, office		28f. Location (City or To	Street and N wn, State)	lumber or Run	al Route Numi	ber,
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	To the vithing complete the com	M	29b. Signature and title of certifier	/ /n.)	2	29c. License	e number		29d. Date si	igned (Month,	Day, Year)	
			But	Win Cle	~~	-	D00646	615		Januai	ry 5, 2	2009	
	12		30. Name and address of person who Genevieve Wroblev				Drive	Rockvi1	le. Mar	vland	20850		
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar	r's Signature	52 5 11			,	Junited			
	Registr		18 N 0 0 200	10 homes	1 1	barket	9						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 00259 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year ALLIE, BRUCE **Physician** 20:40 M 2009 lanuary /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Hospita 6. sex imore Hay box If Under 24 Hrs. 8. Date of Birth Hours Min. Month Day, 9. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 212-22-4901 Months Days 1 □ M 2 💢 F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. W. Alcal Evan is at orbit to a page. 1**X**Yes 2 □ No Completed by Funeral Director imore 10f. Zip Code 10g. Citizen of What Country? 229 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) dary (0-12) are rovide Father's Name (First, Middle, Last, Maiden Surname) Be ဥ 19a. Informant's Name/Relationship (Type. Print) or Rural Route Number, City or Town, State, Zip Code) MD 21229 1205 Kober 20c. Location - City or Town, State Place of Disposition (Name cemetery, crematory or of 20a. Method of Disposition 1 Bunal 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5 3 Removal from State Jan. 10, 09 5 ☐ Other (Specify) e of Funeral Service License 21. Signatu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** pheumonio in known /Medical Due to (or as a consequence of): Examiner PSis In Known Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 5 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed? Yes 2 ☑No After this certificate 1 □Yes al or Attending Physician: 1 s after death. Il Director: After this certifica ed in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28c. injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 No 2 Accident 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Defertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) onnuar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day,

porte

3001

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** 200 Jancare Catherine W. Barnes /Medical 4b. City, Town, or Location of Deatl 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner saltimore cosedale Square 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex (In vrs. last birthday) **Funeral** Voq r Min. 1 □ M 2 🛛 F 82 Months Days Hours July 18,1926 Maryland Director 219-20-6670 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County show the Marylar ?? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Examinat must be notified at 1 □Yes 2 No Director Chase Md. Balto. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 1 USA 21220 Completed by Funeral 7413 Greenbank Road filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married altimore, Maryland 21215-0036 other than "natural", or 1 ☐ Yes 27 No Specify: Specify. White 3 🗆 Widowed 4 🗖 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Mental Hygiene. Construction Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marguerite S. Schwemm W. Irving Wentz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 i DTR. 7413 Greenbank Road Chase, Md. 21220 Wendy Laidler permit. Pages 1 and:
Deportment of Health
Important: If item 27
any njury or other tr
once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1- 12-2009 Balto. City Bayview 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final magn Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a conse ence of): Division of Vital Records, P.O. Box 68760, Physician/Medical been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 7 Yes 3□ Probably 4□ Unknown 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b irector, page 2 s autopsy performed 1 ☐ Yes 2 No this certific al director, 25. Was case refe or to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊟No 2 R/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 TYes 2 □ No death. 2 Accident after death Director: A 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mol

32.

egistrar's Signature

1/2

29c. License number

6530 Walthen Brenue Balfomone

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Dav **Physician** Рм Regene Ε. Bowen Jan. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 7930 Main St. Baltimore Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days | Hours | Min. | Nov. 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1939 1 □ M 2 🖾 F 69 214-44-3059 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Baltimore Maryland Anne Arundel 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7930 Main Street 21226 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Household 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Andrews Mavis Smothers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard F. Bowen Sr. 7930 Main Street, Baltimore, MD 21226 (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Jan. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Lorraine Park Cemetery Baltimore, Maryland 21. Signatura of Funeral Service 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARCINOMI **Physiclan** TRENY /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for 1 in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a d be detached f 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death-but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1) Meath 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has 2 No Division of Vital 1 ☐ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 DNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Umural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Locatifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 21684 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RITCHIE LOWY PASADENA

DHMH 17 Rev 1/2001

State Registrar Day, Year) 2009

2. Registrar's Signature

For amend #20b Per State of Maryland Department of Health and Mental Hygiene Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** BROCKLINGITON JANUARY JUANITA 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 2 😾 F 217-40-7712 64 9, 1944 Maryland **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ä XM☐Yes 2☐No Director N/ABaltimore or than "natural", or items 23a or 28a-f s the Medical Examiner must be notified Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 110 N. Central Avenue Apt.219 21202 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2€ No Specify. δ 3 € Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Nurse Caretaker Private Duty Unk. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edna Osborne Williams ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 610 17th Avenue Springfield, Tenn. 37172 permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra William Anthony Harry/Son Date 09 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion Cemetery 1/10/08 Lansdowne, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility hatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, entock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** EARS DIABETES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examine Due to (or as a consequence of): death certificate be executed burial-trar and resulting in death) Last Due to (or as a consequence of): physician Box 68760, Physician/Medical use as the ding p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy ate has been signed by the atter page 2 should be detached for in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 □ No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 1 TYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 2 - No 1 Yes this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certifica completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 ER/Outpatient 3 □ DOA 1 Inpatient မ 27. Mann f Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 2 Accident 1 🔲 Yes 2 🗌 No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of/¢ertifier 29d. Date signed (Month, Day, Year) RES-000 2009 acqui JANUARY

State Registrar limothly

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAEGER

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 00263 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2009^{Year} Day **Physician** January 6, 11:55 AM Joseph Daniel Boone /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Harford Bel Air Upper Chesapeake Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 23, 1924 West Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □XM 2 □ F Director 84 <u>236-38-5540</u> Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits Department of Health and Mental Hygiene. Important: if item 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its mostical Examinant in interest to inclined at Director 1 ☐ Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 323 E. Belcrest Road 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or ite 1 ☐ Never Married 2 X Married 1 XYes 2 If Yes, Give 1 □Yes 2 XNo Specify. \$ 3 Widowed 4 Divorced Year or Dates White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ Hazle Clarence Boone Macel (nmn) Paxton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita P. Boone / Wife 323 E. Belcrest Rd., Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carmel Cemetery 1-12-09 Bel Air, Marvland permit. 21. Signature of Funeral Service Licenses MCComas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ommuni wired neum day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) □Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No 1 □ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 6 ☐ Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours af To the Funeral D Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated.

Maryland

more,

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Maria

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carril

.M.D.602

32 Registrar's Signature

parke

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#17, 18perFH, G887, 1/13/09, WS
State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State Registrar 700 W. 40 th

32. Registrar's Signature

Street, Baltinira, Md 21211

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TIBBULE MACGREGOR

31. Date filed (Month, Day, Year)

JAN 0 9 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10:18 PM Robin Denise Campbell DI 05 09 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOSDICE IOWSON Baltimore Gilchrist 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 212.80.035 1 □ M 2 💢 F **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I're Medical Examinat must be notified at 1 XYes 2 □ No Director MD Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1XNever Married 2☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, I'm Medie once. Elementary/Secondary (0-12) College (1-4or 5+) Visa, Inc Directo 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (ampbell) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1502 Kenhill Avenue Baltimore MD Doris Campbell 20a. Method of Disposition /Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 01/09/09 New Cathedral 22. Name and Address of Facility Vaughn C. Greene Funara | Services 21. Signature of Funeral Service Licensee Road Randallstown, MD. 21/33 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** BREAST CANCER 2007 disease or condition resulting in death) METHSTATIC /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months?

1 Yes 2 No
9 Unknown Year Month 5 ☐ Other (specify) signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed this certificate has been al director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending 24 hours after death. 1 🙀 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D64395 JANUARY 6, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

DANIEUE DOBERMAN,

31. Date filed (Month, Day, Year)

MA

Registrar's Signature

65705 N CHARLES ST. SUITE 209 BALTIMERE, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00266 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 152AM LRAMEN 009 /Medical Eacility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** NIA N/Qi tospital Ba Himore If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Hours 231.40.1409 0 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar mast be notified at Kandallstown 1 ☐ Yes 2 No MD Baltimore Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8812 GIIN USA 21133 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 11. Marital Status 14. Race - American Indian. Black, White, etc Armed Forces 1 XIYes 2 I If Yes, Give Year or Dates 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify. Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Bethlehem Elementary/Secondary (0-12) College (1-4or 5+) Rigger 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clark Fannie Chem treeman Pages 1 and 2 should nent of Health and Mer 19a. Informant's Name/Relationship (Type. Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21133 Kandalistown 8812 Gilly Way 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Important: If it any Injury or conce 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Laurel, MD 0 09 oun C. Greene Funeral SICO 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Koad Kanda Ustown MD 21133 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocarutal 10 hip disease or condition resulting in death) /Medical Du to (or as a consequence of): Examiner LOVELANY ar if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the burial Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) signed by the a 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2. No 1 🗌 Yes 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 2 XN0 1 ☐ Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 ✓ Natural 2 ☐ Accident 5 Pending investigation thours after death.

uneral Director: A
ely filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 156 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00033330

State Registrar 3333

32. Registrar's Signature

N. Calvert

21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stoke

John

JAN 09 2009

31. Date filed (Month, Day, Year)

Mayresa Crast Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-00112 State of Maryland / Department of Health and Mental Hygiene **UNK UNK** Certificate of Death 1- For State Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day January 4, 2009 2252 hrs Medical Examiner c. County of Death 4b. City, Town, or Location of Death: Facility Name (if not institution, give street and number) Baltimore Johns Hopkins Hospital g Birthplace (State or Foreign 8 Date of Birth (MM/DD/YYY) If.Under 24Hrs. If Under 1 Year 7. Age (in yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Hours Months Days Director М 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 No 28a-f show event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country 10e. Street and Number or items 23a 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes 2 X No ift Pages I and 2 should be given by the man of the fact of the month of the fact of the man of the man of the man of the man when the man when the man "natural", or yor other trannatic event. the Medical To Yes 2 X No specify: f Yes. Give Year Divorced Widowed Ď. 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 18 Mother's Name (First, Middle, Maiden Surname) hather's Name (First, Middle, Last) Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Inf rmant's Name/Relationship (Type, Print) Social Worker 19b. Mailing Address Udom 20c. Location - City of 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition Baltimore, crematory or other place) X Burial 2 Removal from State Cremation 3 Donation 5 Other Specify Name and Address of Facility ignature of Funeral Service License Approximate Interval Between Onset and dised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or Part I. Enter the disease, or complication failure. List only one cause on each line Physician Medica a. Gunshot Wound of Abdomen Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical X AMENDED attending physician or use as the burial -UNPENDED Ttem<u>#19a.perFH.G887.1/9/09.WS</u> Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of preg 3b. Was decedent pregnant in the Month Day Year Live birth Fetal death past 12 months' Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Yes 2 ✔ No 3 Probably 4 Unknown ģ Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? this certificate has performed? Yes ✓ Yes 2 1 🗸 26.Place of Death (Check only one) 25. Was case referred to medica Division of Vital Be Other₄ examiner? Residence 6 Other: Hospital: 1 🗸 Inpatient 2 Nursing Home 5 DOA ER/Outpatient 3 1 ✔ Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month Day,Year) Jan 4, 2009 28b. Time of Injury 27. Manner of Death Subject shot Certification: 1949 hrs Natural Yes 2 V No Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) 5616 Loch Raven Blvd., Baltimore, Md. Suicide (Specify) residence determined 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

the Hospital or Attending Physician: The nin 24 hours after death. The Funeral Director: After this certificatpletely filled in by the funeral director, pa To the

> 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Russell Alexander MD.

29b. Signature and title of certifier

31. Date filed (Month, Day,

and manner stated

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

State Registrar 29d. Date signed (Month, Day, Year)

January 5, 2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Day 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8. Date of Birth Month, Day, Y Age (In vrs. last birthday) Birthplace Gountry) **Funeral** 1**X** M 2□ F Months Days Hours Min. Director 10b. County 10a State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Funeral Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Keceiving 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ 19a. Informant's Name/Relationship (Type. Print) (wite) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licensee W. North Ave. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart fadure. List only one cause on each line. 23a. Party Enter the dis shock, or heart fall Immediate Cause (Final epatocell **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Medical Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 ∣∐Yes 1 🗆 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one 6 Wher (Specify) HOSPICF Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 28a. Date of Injury (Month, Day, Year) Manner of Death
Natural
Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation after death. 1 ☐ Yes 2 No filled in by the 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar DHMH 17 Rev 1/2001

ORIGINAL

29c. License number

ctelsen

10d. Inside City Limits

Md. 21215

Approximate Interval Between Onset and Death

Day

2 No

Year

4 Unknown

1 Yes 2 □ No

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print) endcell (That ke emb 555W)

32. Registrar's Signature

se	Type or Print in Black Indelibi	e ink. Er	nsure All Co	pies Are Le	gible.
	State of Maryland / Departmen	nt of Heal	Ith and Menta	al Hygiene?	000

00270 Mental HygieneZ U U S 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JANUARY **Physician** 02:00A M EDWARD L. CLINGAN 2009 /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 22, 1933 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min XIX M 2 F 215-32-4331 75 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ... any injury or other traumatic events. 10d. Inside City Limits 10a. State 10b Counts 10c. City. Town or Location 1 ☐ Yes 2 ☑ No Maryland Harford County Director Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21009 501 Eastview Terrace Apt. 3 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: Completed by If Yes, Give Year or Dates: Specify: 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 yrs. College (1-4or 5+) Installer A.T.&T. Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irvin Clingan Helen Purdum 2 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 206 High Meadow Terrace Abingdon, Md. 21009 Bob Clingan (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State Parkwood Cemetery 1-10-2009 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Lassann Funeral Home 3. mara 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CONGESTIVE HEART FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CARDIOMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed aftending physician and for use as the hurial CORONARY ARTERY DISEASE
Due to (or as a consequence of): O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown END STAGE RENAL DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral D

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D@@17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

State Registrar

AH

31. Date filed (Month, Day, Year)

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TOWSON MARYLAND 21204

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Dhusi	nion.	1. Decedent's Name (First, Middle, Last	01 10			. Date of Death	Day		Time of Death
Physi /Med		Kuth M.	Chalt			01 0	3 á	2009 3	3:20 PM
Exam Funera Directo	1	4a. Facility Name (If not institution, give 1. Constitution of the second of the seco	ores Nursi	ng Home	EX / 19/00 If Under 4 Hrs. Hours Min.	Date of Birth	St. County	Mary	State or Foreign
inyland show		10a. State 10b. County	10c. City	, Town or Location	/				side City Limits
tha Ma 28a-f s	ecto	Virginia Westmore	land Lo	10f. Zip Code	h	10- (Citizen of M.	/hat Country?	Yes 22(No
th with 23a or	ai Dir	251 Clegrview	Drive	2244	13	log. c	U5,	A	
Baltimore, Maryland 21215-0020 parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haaith and Mantal Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Madical Examinat must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	S. 13. Was Decedent of Hi If Yes, specify Cubal 1 Yes 2 No	spanic Origin? (Specif n, Mexican, Puerto Ric Specify:	y Yes or No- ean, etc.)		American Inc.	dian,
215-0020 thin 72 hours af e. an "natural", or Medical Exam	eted	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>	16a. Decedent's Usual Occupa (Give kind of work done of	lurina most of workina	16b.	Kind of Bu	siness/Industry	
212. J withir jiene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	HOMEMAK	. /	(Twn	Hom	0
ind be filled tal Hygid dother svent, I	Be B	17. Father's Name (First, Middle, Last)	1/ /.	7,1	18. Mother's Name (F	First, Middle, Maide	en Surname	9)	
Maryland of 2 should be file th and Mantal Hy 7 is marked othe	ဥ	19a. Informant's Name/Relationship (Ty	N CSS/C/	19b. Mailing Address (Street a	/ Yay Mc	Gal Gal	gler	State Zin Code	
and 2 sauth an n 27 is ier trau		Sugar T	UIS Daughter	251 Cleurvich	7. 1	olonia/	Beech	State, ZIP Code	22443
Baltimore, barnit. Pages 1 ar Dapartment of Haa mportant: if Itam; mny injury or other		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 ★ F	20b. P	lace of Disposition (Name of emetery, crematory or other lace	e) /	Date 20c.	Location - 0	City or Town, S	tate
Baltimo pamit. Page Dapartment Important: If any injury or		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	Res	22. Name and Addres	ctery 01-	08-09 /	//enti	oun, P	4
Dapa Jany impo		1. Signature of Pureral Service Licens		502 0	Sol Packilly Web	er Funera	PA	me, r.C	2
		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused the death	n. Do not enter the mode of dying	g, such as cardiac or n	espiratory arrest,	111	Appr	oximate val Between
Physician /Medica			N	+ '					et and Death
Examine		Immediate Cause (Finat disease or condition resulting in death)	Demon	uq				7	ears
D #	iner		Dopre	r as a consequence of):				y	cars
68760,000 ficate be axecuted physician and is the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate	Due to (or	as a consequence of):				9	
68760, ficate be axe physician at the burial-t	edical	Cause (Disease or injury that initiated events	Due to (or	as a consequence of):				3	ceus
(ecords, P.O. Box 68/60, ()) law requires that the death certificate be assocuted as been signed by the attending physician and 2 should be detached for use as the bunal-transit	/Med	resulting in death) Last		,				1	
IS, P.O. BOX (as that the death certifieded by the attending be detached for use a	Physician/M	Part II. Other significant conditions cor	tributing to death but not resu	ulting in the underlying cause give	on in Part I	23b. Did tobacc	O HEE COD	tribute to the	rause of death?
E by the etache	Phys		in butting to abatif out flot fort	ining in the underlying cause give	arrite art t.	1 ☐ Yes			4 ☐ Unknown
dS, liras the signed Id be d	b					24a. Was an aul	onev	24h Were au	topsy findings
COLD w require s bean si	ojete					performed?	орзу	available	prior to on of cause
The ate h	Completed					1□ Yes	20No	_	2□ No
VITAL I sician: The cartificate fractor, pag	æ	25. Was case referred to medical examiner?	lospital:	CD/Outputient 20 DOA Othe	26. Place of Death (C				
Phys raldi	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of 28c. Injury	4)ZJ Nursing Home	5 Residence Describe how in			
VISION OT VITA Attending Physician: Ir death. ector: After this cartific by the funeral diractor.	ation	1	(Month, Day Year)		:? ∕es 2□No				
DIVISION OT tal or Attending Phy rs after death. al Director: After this led in by the funeral of	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factory, office)	28f.	Location (Street a City or Town, Sta	and Numbe ite)	er or Rural Rout	e Number,
To the Hospital or A within 24 hours aftar To the Funeral Dire complatally filled in b	edical	29a. Certifier (Check only one) 1	sician: To the best of my knowner: On the basis of examinat and manner stated.	vledge, death occurred at the timion and/or investigation, in my op	e, date and place, and inion, death occurred	due to the cause(at the time, date a	s) and mar nd place, a	nner as stated. nd due to the c	ause(s)
To the To the Comp	≥	29b. Signature and title of certifier	Helelia	29c. License	6 046	29d. D	ate signed	(Month, Day,)	(ear)
5		30. Name and address of person who co	mpleted cause of death (Item	23a) (Typo, Print) Centernia	Q84, L	Plata,	MD'	2064	6
	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure					
Regis	-	JAN 0 9 2009	General S. A	Backet .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00272 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ida Mary Comegna TAN 1305 M 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL BALTIMORE 4GNES 8. Date of Birth (Month, Day, Year, Jan. 7, 19 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 🖾 F Months Days Hours 212-07-5648 92 1916 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Rolling Farm Court 21228 USA 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify SpecifyWhite 3 Nidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Produce Manager Food17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Tognocchi Corinna Pesica 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Hay Pasture Court; Catonsville, MD 21228 <u>John J. Comegna</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Mem. Park 1/9/2009 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue: Catonsville, MD 21228

Examiner the Hospital or Attending Physician: The law requires that the death certificate be Records, OMEGNA Vital Division of

Physician

/Medical

Director

Funeral

Completed by

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Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaminar must be notified at once.

Physician /Medical

attending physician and for use as the burial-transit

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached

Baltimore, Maryland 21215-0036

	23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do not enter the one cause in each line.	mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between				
	Immediate Cause (Final disease or condition	a INEUMONIA				Onset and Death 4 DAYS				
	resulting in death)	Due to (or as a consequence of):								
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Undersying Cause (Disease or injury that initiated events	b				,				
dical Exa	resulting in death) Last	Due to (or as a consequence of):								
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		opic pregnancy er (specify)		23d. Date of de Month	livery Day Year				
ed by PI	DIABETES									
Somplet	DEMENTI			24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of				
Be	25. Was case referred to medical examiner?		26. Place of Death	h (Check only one)						
	1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3	□ DOA Other: 4 □ Nursing Ho	ome 5 Residence	6 ☐ Other (Spe	ecify)				
ation:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Work?	28d. Describe how in	ury occurred					
Certification: To	3 Suicide 6 Could not be determined		actory, office	28f. Location (Street City or Town, St	and Number or Ri ate)	ural Route Number,				
edical	29a. Certifier (Check only one) 1 ✓ Certifying Ph	hysician: To the best of my knowledge, death occuminer: On the basis of examination and/or investigand manner stated.	urred at the time, date and place, pation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner a and place, and due	s stated. e to the cause(s)				
Ž	29b. Signature and litle of certifier	110/ 115	29c. License number		Date signed (Mont	h, Day, Year)				
	MShali	NOT IVID	00054257	J	ANIO	6/2009				
		completed cause of death (Item 23a) (Type, Print) 1 OS P. 900 CATO		SHAR 4LTIMO	RE - 2	21229				

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State

Registrar

n. 0 2009

31. Date filed (Month, Day, Year)

900

32. Registrar's Signature

1.					For	se Type or Prir State of Ma		I ndelible Ink epartment of I		•	•	
THE PART OF THE PA					1 - State Registrar			Certificate of	Death		Reg. No. 200	9 00273
Scale Security Number of treat characters, pass active and number of Trimonistical Stabila Maria Hospitals Stabila Maria Hospitals (Los of Park 1998) and the stability of the s										Month		3. Time of Death 12:30P.M
Description of the property of					Stella Maris Hos	spice	_	Ti	monium		Baltimor	e County
The control of the co					233-34-2553	6. Sex. 7. Ag 1 ☐ M 2 ☐ F	e (In yrs. last birth 61 Y	Months Days		8. Date of Bir (Month, Da April	9. Bi 23 , 1 927 Mor	rthplace (State or Foreign Country) Gantown, W.VA
Comparison of Comparison of			Maryland a-f show	ctor	10a. State 10b. County	ore County						10d. Inside City Limits 1 □ Yes 2 No
Comparison of Comparison of			th with the 23a or 28	al Dire		ley Road u	nit F004		21093		-	
Comparison of Comparison of	р.ш. 036	980	urs after dea al", or items	by Funer	1 ☐ Never Married 2 Marrie	Armed Forces? 1 ☐ Yes ②□ If Yes. Give				Specify Yes or No to Rican, etc.)		
Comparison of Comparison of	30 5-0	2-0	72 ho	eted	15. Decedent's	s Education	16a. I	Decedent's Usual Occu	pation during most of wo	erkina	16b. Kind of Business	s/Industry
OF CATE Committed Commit	2.			i di		7	>+ } I			······································	Incurs	nce
Taffy O'Shea (Daughter) 200	7	land 2	ald be filed w Mental Hygie rked other t	o Be Co					18. Mother's Na			
Company Comp	<u>,</u> ≥	Σ	od 2 still all lith all 27 is				I .	-				
Physician Medical Examiner 23a Fart find the displace or complicative that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, incomplication to complete the cause of the caus	JARY	more	Page nent c int: if		1 ☐ Burial 2 ☐ Cremation					Date	_	
Immediate cause (Final disease or condition resulting in death) Due to (or as a consequence of):	JANI	Balt	permit. Departr Importa	once.	21. Signature of Funeral Service L	1 (10.	, Dz.	Peaceful A	Alternati Road	ves Fund Timonium	eral&Cremat m, Maryland	ion Ctr.,P.A.
Due to (or as a consequence of): Due to (or as a consequence of):		and a	Physicia	an l	Immediate Cause (Final			ot enter the mode of dy	ing, such as cardia	ac or respiratory a	arrest,	Approximate Interval Between Onset and Death
Due to (or as a consequence of): Column Col	٩		/Medic	al	resulting in death)	a		f):				
The state of the s	()	, v	e executed sian and urial-transit	-	resulting in death) Last	с						
29a. Certifier Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day 29d. Date s	O. Box 687	O. Box 6870	the death certificate I y the attending physiched for use as the t	ian/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death		су			elivery Day Year
29a. Certifier Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day 29d. Date s	DEZIC rds, P	rds, P	quires that in signed build be deta	à	Part II. Other significant condition	ns contributing to death b	out not resulting in	the underlying cause gi	ven in Part I.			
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29a. Certifier Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day 29d. Date s	Vit I	<u> </u>	certifi rector	Be	examiner?	Hospital: —		Ot	hor:			
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29a. Certifier Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day 29d. Date s	rision	rision	Attending r death. ector: Afte	fication	1 Natural 5 ☐ Pending 2 ☐ Accident investigs 3 ☐ Suicide 6 ☐ Could m	ot be 28e. Place of Ini	ury - At home, far	M 1 [28f. Location	(Street and Number or I	Rural Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093	Ó	á	ospital or hours afte ineral Dire ly filled in I	al Cert	29a. Certifier 1 ☐ Certifying	Physician: To the best	of my knowledge,			ce, and due to the	e cause(s) and manner	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093			To the Ho within 24 To the Fu complete	Medic	one) X Nurses P	ractioner	ated.			curred at the time		
04 Date Filed (Marth Day Wood) 19 10 10 10 10 10 10 10 10 10 10 10 10 10			Ч		30. Name and address of person v	who completed cause of d	death (Item 23a) (1	K19 Type, Print)	9792		1/6/00	1
State 31. Date filed (Montin, Day, Tear) 32 Angistracks Signature			P				anda Ciamatura		TIMONIT	M, MD 2	1093	
Registrar JAN 0 9 2009 Annua B. Agarkel				State istrar			ars Signature	parkel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Patricia Anne Donlin 05 2009 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Good Samaritan Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days 1 ☐ M 2 🗶 F 022-12-3785 87 Manitowoc, WI 09/17/1921 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Parkville MD Baltimore 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 U.S.A. 8800 Old Harford Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Business Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George I. Sullivan Leona Lindstedt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9603 Dundawan Rd. Christine Rogers/Daughter Nottingham, MD 21236 20b. Place of Disposition (Name of cemetery, crematory prother place)
Dulaney Valley
Memorial Gardens Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 01/07/09 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel & Cremation Services 21. Signature of Funeral Service Licensee 88<u>00 Harford Rd. Parkville, MD 21234</u> Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or pearl failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition esulting in death) METASTATIC LIVER Physician /Medical Due to (or as a consequence of) Examiner -01 AN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical The law requires that the death certificate IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown cate has been signed, page 2 should be der Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe this certificate 2 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No Hospital 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manper of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After (Month, Day Year) 1 Natural Injury 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Pate signed (Month, Day, Year) 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 88 Maran Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Marylan		artment of tificate o			6	009	00275
			Registrar 1. Decedent's Name (First, Middle, Las.	?)	Cer	uncate o	Dealli	2. Date of De	Reg. No.		3. Time of Death
	Physicia		Marion	0 0	es			JAN.	Day (o	2009	5:10 A.M
,	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town	, or Location of De		4c. (County of Death	
			Kiverview Car	e Center			sex				MORE
	Funeral Director		5. Social Security Number 6. Se	7. Age (In yrs. I	ast birthday) Yrs.	Months Day		lin. 8. Date of Birl	y Year)	9. Birth	nplace (State or Foreign untry)
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	anylan show	_	10a. State 10b County		, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 No
	28a-f	ecto	10e, Street and Number	Oft	DA	10f. Zip Code			10a Citix	en of What Co	
	death with the Maryland rms 23s or 28s-f show froughte notified at	Funeral Director	2602 Tobo	Noive			21234		rog. Onz	115A	unay:
	death	nera	11. Marital Status	12. Was Decedent Ever in U.	S. 13. V	Bank"		? (Specify Yes or No uerto Rican, etc.)	- 1	4. Race - Amer Black, White	
2	or Ite	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	I □ Yes 2 1 N		20110 1110411, 0(0.)	1	Specify: 1,1	hit:
3	72 hours atter natural, or Ite	ed b	15. Decedent's Ed		16a. Deced	lent's Usual Occ	cupation		16b. Kin	d of Business/I	ndustry
ב ב	thin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	kind of work dor OO NOT use ret	ne during most of ired)	working	4		
7	filed within Hygiene. other than " ant, Ire Ma		8		HOY	remai	7		H	T Hon	n C
	ntal H ed oth ed oth	Be	17. Father's Name (First, Middle, Last)	(50)			18. Mother's	Name (First, Middle,			
2	should nd Me mark matic	To	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailin	g Address (Stre	et and Number or	Aural Route Nymbe	DOTR er, City or		ip Code)
Ž.	nit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan artiment of Health and Mental Hygiene. And credit if the X7 is marked other than "natural", or itema 23a or 28a-1 show injury or other traumatic event, the Medical Examiner must be notified at injury or other traumatic event, the Medical Examiner must be notified at <u>e.g.</u>		Joan Johns	on-daughter	260	2 Jo	nn De	ive BA		nore	1.0 0.0211
5	of He of He if item		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	lace of Dispo emetery, cren	sition (Name of natory or other p	place)	Date		cation - City or	
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0	permit. Departi Importi eny inj		21. Signature of Funeral Service Licen	20 total	22	. Name and Add	dress of Facility 8	SOO HARFO	4 3	6	moremodia 34
			23a. Part1. Enter the disease, of companies shock, or heart failure. List only of	lications that caused the death	n. Do not ent	ar the mode of d	tying, such as care	diac or respiratory a	rrest,	N SERVICE	Approximate
F	Physician		Immediate Cause (Final disease or condition	Alaha.	~ ~	$\sim l$	C	40			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence)	uence of):						
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Bonen	~ C .	,				1	
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Ď :	ding p	/Mec	IF FEMALE:	23c. If yes, outcome of pregna	incv					3d. Date of deli	
ם	death a atten d for u	ician	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \)	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d	Ideath 3	Ectopic pregnal Other (specify)			2	Month	Day Year
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'n	The law requires that the death the has been signed by the atter bage 2 should be detached for u	þ	Part II. Other significant conditions co	ontributing to death but not resi	ulting in the u	nderlying cause	given in Part I.				the cause of death?
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		0	25. Was case referred to medical				26. Place of	1 ☐ Yes Death (Check only of	2 X No	1 🗆 Yes	2 No
<u> </u>	nysici nis cer direc	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA	Del	ng Home 5 Resi		☐Other (Spec	cify)
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	To the Hospitel or Attending Physician: inin 24 hours alter death To the Funarel Director: After this certifics completely filled in by the funeral director, to	edical ((Check only 2 Medical Exam	ysician: To the best of my kno liner: On the basis of examina	wiedge, death	n occurred at the	e time, date and pi	lace, and due to the occurred at the time,	cause(s) a	and manner as place, and due	stated. to the cause(s)
	o the vithin 2 or the ompler	Med	29b. Signature and of certifier	and manner stated.		· · · · · · · · · · · · · · · · · · ·	ense number			signed (Month	
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	n		30. Name and address of person who		-	Print)	1	71 Beltimor			
	- 01	•	Sebastion John 31. Date filed (Month, Day, Year)	3023 Fo.	e terr	since	rre 1	schma	e 1	40 9	1227
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, 2009 Year **Physician** Ruth Elleson January 6:30 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 1926 New York 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Hours Months Days Min 1 M 2 M F 056-22-7535 82 Director April Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" any njury or other traumatic even and other traumatic even ones. 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9817 Veirs Mill Road, #2 20850 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑ Never Married 2 ☐ Married 1 ☐Yes 21 No Specify: White þ If Yes, Give Specify 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Economist Federal Government 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Olaf Elleson 2 Ragna Eide 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David V. Roman / Friend 9830 Cherry Tree Ln., Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 8, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 2009 Bethesda, Maryland Robert A. Fumphrey Funeral Home/Rockville, Inc. 300 W. Montgomery Ave., Rockville, MD 20850-2805 21. Signature of Funeral Service License M00896 23a. Part 1. Enter the diseale, or commercations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death **Physician** preumonia days resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Box 68760 Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant Day Pregnant at time of death 5 ☐ Other (specify) P.O. I 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, completely filled in by the To the Hospital within 24 hours a To the Funeral D

State Registrar

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

Alicia T. Mistry,

31. Date filed (Month, Day, Year) JAN 0 9 2009

9901 Medical Center Drive, Rockville, Maryland 20850 M.D. 82. Registrar's Signature

icia J. Mestry MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

January 5, 2009

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** 4:30 w 009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year If Under 24 Hrs (In yrs. last birthday) 9. Birthplace (State or Foreign ٩ge Months Hours Min. Days 1 M 2 □ F Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Lingits 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 123 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Çuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify <u>ک</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SUBCON 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) TEM200 မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod MARGARET 212 MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Ent +/t th disea or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 | Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 110 1 □ Yes 2 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 1 Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

Hospital or Attending Physician: The law requires that the death certificate be executed and burialphysician the as attending for use P.O. detached þ signed be det Records, page 2 should has certificate of Vital funeral director, this After Division 24 hours after death.

Funeral Director: A filled in by the

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27 is marked other than "natural", or Items 23a or 28a-f show er traumatic event, the final Event in not must be redified at

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/Medical

Examiner

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1 and 2 should be Health and Mental

Maryland 21215-0036

Baltimore,

3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

and manner stated.

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

30. Name and adding of person who completed cause of death (Item 23a) (Type, Print) 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32 Registrar's Signature

State Registrar

Medical

completely

within 2 To the I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 00279 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore BALTIMORE Franklin Square Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Year) Days Months Hours Maryland 17-32-812 72 March 6, 1936 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No White Marsh Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6 United States 21162 6045 Loreley Beach Road 23a Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural" or itemany injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify. Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Plumbing Owner/Operator 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harrah Marrie Seigui John Gaydos 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6045 Loreley Beach Road, White Marsh, Maryland 21162 Joan Caydos - Spouse 20c, Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) parrison Forest VAlience 22. Name and Address of Facility
Evans Funeral Chapel & Cremetion Services — P.
8800 Harford Road, Parkville, Maryland 21234 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** yea disease or condition resulting in death) /Medical Due to (or as a contequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of and attending physician for use as the buria Box 68760 Physician/Medical If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No P.0. detached 9 ☐ Unknown 9 Unknown contributing to deat what wit resulting in the underlying iven in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 La Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital Hospital or Attending Physician; in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 3 ☐ DOA 1 ☐ Yes Medical Certification: To 28a. Date of Injury / (Month, Day, Year) 27. Manner of Dr ath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

31. Date filed (Month, Day, Year)

Dod

Registrar's Sign

Examiner Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Physician

/Medical

Examiner

Director

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Modical Examination and the notified an once.

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attending physician for use as the burial

3altimore, Maryland 21215-0036

Examiner resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed Be 25. Was case referred to medical 1∐Yes 2⊠No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury Injury at Work? 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ann Mulhi Res-000 January 04, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sinai Hospital of Baltimore

State Registrar

Amar Madhuri 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Mangalapudi, mp

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar			of Marylan	•	artment of F ertificate of			Reg. No	2009	00281	
Physicia	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month							ath Day	Year	3. Time of Death		
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Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4d. Harford											
Funeral		5. Social Security I		Nursi B. Sex	ng Cent		Belc If Under 1 Year	amp If Under 24 Hrs.	8. Date of Bir	th	larford	place (State or Foreign	
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D		Usual Residence of	of Decedent						ray 25	1750			
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hould d Me mark matic	ပ	Peter L				19h Mail	ing Address (Street		Hinshaw	er City or	Town State 7	Cada)	
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Dan permi Depar Impol any ir		Mu	RI).	(-/-			9705 Be1	air Rd. N	Notting	nam,	Md. 212	36	
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The cate h	Completed								perfo 1 Yes	2 X No	death? 1 ☐ Yes	2 10	
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Phys this	۲.	1 ☐ Yes 25	₹No ath	28a. Date		ER/Outpatie 28b. Time	ant 3 DOA	4 Nursing H	ome 5 ☐ Resi 28d. Describe		Other (Speci	fy)	
tending eath. tor: After the funer	tion	1 Natural 2 Accident	5 Pending	(Mo	nth, Day Year)	Injury	Wor	k? Yes 2 □ No	Zod. Describe	now injury	Occurred		
Atten deat deat of the	fica	3☐ Suicide	6 Could no	lot be 28e. Place of injury - At home, farm, street, factory, office 28					28f. Location (8f. Location (Street and Number or Rural Route Number,			
al or all	Certification:	4 Homicide		build	ding, etc. (Speci	ty)			City or To	wn, State)			
To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
o the	Mec	29b. Signature an	d title of certifier	A .	1		29c. Licens	se number		29d. Date	e signed (Month,	Day, Year)	
FSFO			17/1	///	MIM	n	D 2	7975		11	6/109		
0		30. Name and add	dress of person v	who completed cau	use of death (Ite	m 23a) (Type	e, Print)	/ / / / /		//_	4/0/		
Ψ		DAV	in m.	,	p 6/1	- mo	chail 1	rd Bel	Air 1	un.	21014		
Sta		31. Date filed (Mo	onth, Day, Year)		Registrar's Sign	ature	-		}				
Regist			JAN 09	2009	Leacher.	1. 4	rackel						
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State of Maryland / Department of Health and Mental Hygiene

		for State Registrar	Otato of Ma	•	Certificate of	Death	Reg.	No. 2009	00282		
Dhysisi		1. Decedent's Name (First, Middle, Las	st)			1	2. Date of Death Month	Day Year	3. Time of Death		
Physician /Medical		Melvin A.		Sr.			TAZKAVI	774 200	18 6 30 PM		
Examir	ner	4a. Facility Name (If not institution, giv	e street and number)	4.1	4b. City, Town, o	r Location of Death	2000	4c. County of Deat	n 2 ha ard		
Funeral Director		5. Social Security Number 6. S 218-07-7851	ex 7. Age □ M 2 □ F	(In yrs. last birt	hday) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye Jan. 25	9. Birt (ar) Co	hplace (State or Foreign untry)		
I ey, IVICAL YICALIO ZIONOSOO s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinatings to a contined at		Usual Residence of Decedent 10a. State									
	ţō	Maryland Anne Arundel Baltimore 1 □ Yes 2 ☑ No.									
	Director	10e. Street and Number 10f. Zip Code						Citizen of What Co	untry?		
	Funeral	8019 Ft. Smallwoo	od Road	ver in ITS	13 Was Decedent of H	21226	tify Yes or No-	USA 14. Race - Ame	rican Indian.		
	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☑ Yes 2 ☑ No If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		ican, etc.)	white			
	Completed	15. Decedent's Ed (Specify only highest gra	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	oation during most of working	16b	16b. Kind of Business/Industry					
within lene.	dmo	Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver					Transportation				
in yearloo Z 1 Z thould be filed within nd Mental Hygiene. marked other than matic event, the M	Be C	17. Father's Name (First, Middle, Last,)			18. Mother's Name	(First, Middle, Maid	den Surname)			
alylal should be and Ments s marked umatic e	2	Oscar Grim				Dora	Noll				
VICITY SHOT IN A IN A IN A IN A IN A IN A IN A IN		19a. Informant's Name/Relationship (l Route Number, City or Town, State, Zip Code)				
iges 1 and 2 in of Health If Item 27 I		David C. Grim Sr.	. (son)		019 Ft. Sma Disposition (Name of y, crematory or other pla	Da	ate 200	More, MD Location - City or			
		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special				!	12 19 Ba	ltimore	Maruland		
diti		4 Donation 5 Other (Specify), Cedar Hill Cemetery 2009 Baltimore, Maryland 21. Signature of Funeral Service (Service) 22. Name and Address of Facility Stallings Funeral Home, P.A.									
0 89 E 8 8		23a. Partit. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
- Physician		immediate Cause (Final disease or condition	one cause on each line	172Va	Price	ng, such as cardiac or	respiratory arrest,		Interval Between Onset and Death		
/Medical Examiner		resulting in death)	Due to (or as a	consequence					0.00		
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	eonsaquierice d	Marce				onys		
cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	· Shop	14/26	10cc	Acreca	Say	ces	DMS		
oo / ou, rifficate be executed ng physician and as the burial-transit		resulting in death) Last	Due to (or as a	consequence	of):				-		
ficate ficate physics the t	Medical		d								
DOX eath cer attendir	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown In the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown						23d. Date of del Month	ivery Day Year		
S, F. es that t igned by be detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown			
ecords, law requires t as been signe 2 should be o	eted										
on or vital records, F.O. ding Physician: The law requires that the de h. After this certificate has been signed by the funeral director, page 2 should be detached	Completed						24a. Was an autopsy performed	prior to death?	ntopsy findings available completion of cause of		
VITAI sician: T certifica rector, p	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No									
g Phy g Phy ter this	2:	27. Manner of Death 28a. Date of Death 28b. Imper of Death 28c. Injury at Death 28d. Describe how injury occurred									
SIOT tendin eath. or: Af	catio	2 Accident investigation M 1 Yes 2 No									
INISION Or Attending after death. Director: After	Certification	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)									
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one)									
To the within To the compl	Me	29b. Signature and title of certifier 29c. License number 29d. 30. Name and address of person who completed cause of death (Item 23a) (Type, Brint) 30l. Hay And Drive Clay Durvie and 2066 31. Date filed (Month, Day, -Year) 32. Registrar's Signature							d. Date signed (Month, Day, Year)		
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5+1		30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, Print) DA	Rues M	. Come	erod "			
St	ate	31. Date filed (Month, Day, -Year)	2. Registra	r's Signature	LICEVALE	(per	01061				
	trar	18 N A Q 2000	Buckey	A. 1	and						

Registrar

State

18) (Type, Print) N. Churles &, Balto. Md 2120x

30. Name and address of person who completed duse of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

6701

anka

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-00128 State of Maryland / Department of Health and Mental Hygiene Gloria Golightly Certificate of Death 1- For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1545 hrs January 5, 2009 GLORIA A. GOLIGHTLY Medical Examiner 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** N/A 6019 Bellona Avenue 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Secunty Number **Funeral** Country) MARYLAND Months Davs 11/16/1947 Director 212-50-0835 2 X F M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County any 10a. State 1 X Yes 2 No BALTIMORE CITY 23a or 28a-f show notified at once. N/A MD Director 10a. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21212 USA 6019 BELLONA AVENUE 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral items White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 Married Yes 2 X No WHITE 1 Yes 2 X No specify: 4 X Divorced If Yes, Give Year Widowed <u>≨</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within 72 hours a nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natura during most of working life. DO NOT use retired) Completed Flementary/Secondary (0-12) College (1-4 or 5+) SELF EMPLOYED narked other than "event, the Medical 21215-0036 ARTIST 12TH GRADE 18.Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) ANN HENNEGAN Be EDWARD C. SEMONE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 44 BARDEEN COURT TOWSON, MD 21204 timore, MD nt: If item 27 i: other transas PATRICK SEMONE/BROTHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State METRO CREMATORY. 1/7/2009 CATONSVILLE, MD Donation 5 Other Specify 22 Name and Address of Facility 21. Signature of Fungral Service Licensee THE JOHNSON FUNERAL HOME, MO1139 TOWSON, MD 8521 LOCH RAVEN BLVD. 21286 200 2 a. Part I. Enter the disense, or Implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical a. Diphenhydramine and lorazeram intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit 23a,27,28a-f, permE, ca AMENDED X UNPENDED attending physician for use as the burial Physician/Medi Box 68760, The law requires that the death certificate be 23d. Date of delivery 23c. If yes, outcome of pregnancy IE EEMALE Day 23b. Was decedent pregnant in the Month Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify Yes 2 No 9 V Unknown 9 Unknown ed by the detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 No 3 Probably 4 ✔ Unknown ģ page 2 should be Completed 24b. Were autopsy findings available 24a. Was an has been prior to completion of cause of autopsy death? 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one)

Death

Year

2

January 6, 2009

of Vital Records, certificate To the Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be Other: examiner? Hospital: 1 Residence 6 🗸 Other: Scene Nursing Home 5 Inpatient 2 FR/Outpatient this 1 Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death After Certification: unk 1 Yes 2X No Division Natural 5 Pendina 24 hours after death.: Funeral Director: 1/5/09 FD 3:40 DI the Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6019 Bellona Ave filled in by - At home, farm, street, factory, office building, etc 28e. Place of Injury Could not be Suicide residence Baltimore, (Specify) Homicid Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only Medical 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 1 and manner stated 29d. Date signed (Month, Day, Year)

32. Registrar's Signature

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State

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29c. License numbe

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifie

Carol Allan, MD

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Hairfield January * 14:30 PM 2009 Joanne /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Bayriew Medical Center Baltimore Hopkins If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Day, Year, Social Security Number Birthplace (State or Foreign Country) 6. Sex Funeral 1 □ M 2 🔀 F 217-38-1413 March 28. Virginia Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State ed other than "natural", or Items 23a or 28a-f show event, the Medical Examination at Baltimore Dundalk Maryland Director 1 ☐ Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1734 Stengel Avenue 21222 USA Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕍 No Specify If Yes, Give Year or Dates: à Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry
Baltimore County 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Public Schools 12 years Instructional Assistant permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leon Homer Sullivan Carletta Lucille Walton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ray J. Hairfield Husband 1734 Stengel Avenue, Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery 20c. Location - City or Town, State January 1 Burial 2 □ Cremation 3 □ Removal from State 10, 2009 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Skinature of Fundral Service Licensee Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease, of complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intracerebral Hemorrhage 10 DAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.0. the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an certificate has page 2 autopsy performed? Yes 2 1 No death? 2 No 1 □Yes 1 ☐ Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation spital or Attendi nours after death. neral Director: A / filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 6 24 hours at To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) RES - 000 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Baltimore. Mihee MD Eastern Avenue 21224 MD

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23e Per FH G887 1/27/09 JH Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ANY RY 2000 **Physician** 12:54A M Hicks Marie /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson Joseph Medical Center 8. Date of Birth (Month, Day, Year) November 7, 1931 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** Min. Months Days Hours Maryland 1 □ M 2 🛛 F 216-28-2011 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shoi traumatic event, the Pesical Exambra must to red fined at 1 ☐ Yes 2 ☐**X**No Director Maryland Dundalk Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21222 USA 1931 Denbury Drive Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 10 years permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edwin Sible Barbara Gossman ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Daniel Daughter 3707 Rockdale Road, Manchester, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lake View Cemetery 20c. Location - City or Town, State 20a Method of Disposition January X Burial 2 ☐ Cremation 3 ☐ Removal from State 9, 2009 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. nthone 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician RESPIRATORY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DAYS SEVERE MULTISYSTEM ORGAN FAILURE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed physician and the burlal-transit SEVERE CHRONIC OBSTRUCTIVE FULMONARY DISEAS YEARS Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p for use as t JE FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year s been signed by the s should be detached 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Retvo Den toneal bleed. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by tro Deritoneal XX No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has i, page 2 s autopsy certificate I 1 TYes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 1 Natural 2 Accident Date of Injury (Month, Day, Year) 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred 5 Pending Injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) Date signed (Month, Day, Year) 29b. Sign 29c. License number d title of certifier ature a D35453 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 TOWSON, MARYLAND 21204 DRIVE 31. Date filed (Month)-Day, Year) 7671 OSL ER 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Anuan AMES 2009 /Medical Facility Name (If not institution, give street and number) or Location of Death County of Death Examiner Hospice 5401 old C altimore 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1**X**M 2□ F Months Min Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: I filem 23 is marked other than "natural", or items 23a or 28a-s show any hjury or other traumatic event, it is the fical Examiner must be notified as Director 1 ☐ Yes 2 No 10f. Zip Code Citizen of What Country? 5 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 No If Yes, Give Year or Dates: 1950 - 1953 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No à Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RUCK DRIVER 17. Father's Name (First, Middle, Last) Be ဂ္ Informant's Name/Relationship 19b. Mailing Address (Street and Number r Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of Cametery, crematory or other place)
AORRISON FOREST 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5 3 Removal from State Owings Mills, MD 5 ☐ Other (Specify) pecne Funcial Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart believe. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or set a nonecouerine of) be executed burial-transit Due to (or as a consequence of): attending physician for use as the burial Box 68760. Physician/Medical ospital or Attending Physician: The law requires that the death certificate hours after death. IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. I s been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ğ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has b 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perforn certificate I 2 100 2 🗆 No 1 ☐ Yes 1 ☐ Yes After this certification funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Pother (Specify) HOSP C 1∐ Yes 2 📮 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manne eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Di atural within 24 hours after too...

To the Funeral Director: Aft 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier NO 30. Name and addre completed cause of death (Item 23a) (Type, Print) Day, Year) 31. Date filed 32. Registrar's Signature State Registrar

State Registrar PHELIP

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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5. ATHOOD ROAD

State of Maryland / Department of Health and Mental Hygiene 2009 00289 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Thelma III arlso &:35 AM 5 200 9 4c. County of Death January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore washington medical Center Glen Burnie Anne Arunde 6. Sex If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 8. Date of Birth (Month, Day, May 21 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🖾 F Hours Min 214-24-8281 Yrs MD Director Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a livelical Examinar mast be neithed at Director 1 ☐Yes 2 TNo Anne Arundel Pasadena 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country 106 Ken-Mar Avenue Funeral 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 ☐No Specify Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) l be filed within 7 Anne Arudnel Co. Elementary/Secondary (0-12) College (1-4or 5+) Secretary Public Schools Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be fil and Mental F Be Tegeler Harry Α. ဂ္ Frances Schaeffer and i 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health Important: If item 27 i any Injury or other tra once. James J. Hartsell (spouse) 106 Ken-Mar Avenue, Pasadena, MD 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Jan. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Glen Haven Cemetery | Glen Burnie, Maryland 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or conshock, or heart failure. List or liderions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Carcinoma ASTETIC disease or condition resulting in death) UNENOWN /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed as the burial-tran and Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown cate has been signed by page 2 should be detach Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 □Yes 2 110 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1No 1 Impatient this Certification: To 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 🗆 No 2 Accident 24 hours after death Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO0 224£3 mo 30. Name and address of person who pleted cause of death (Item 23a) (Type, Print) Dr. Glen Burne, mp 2106 305 Noental mp Jacobs 2. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 0 9 2009 Registra

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State of Maryland / Department of Health and Mental Hygiene, 00290 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year RR **Physician** 21:52 M January 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITa Itimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral X**X M 2□ F Days Hours Months 332.40.7554 Director 62 NOV 11, 1946 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ral", or items 23a or 28a-f show Evarities must be notified at 1 ☐ Yes 2√√ No Funeral Director GLEN BURNIE ANNE ARUNDEL 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code **USA** 104 LEYMAR RD 21060 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☑Yes 2 ☐ No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2¥XNo Specify. Specify: WHITE Completed by 3 Widowed 4 Divorced "naturai" Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Mudical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) DEBT NEGOTIATOR OWN BUSINESS 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be P WILLIAM L. HART SHIRLEY HANLAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S item 27 LINDA GARLAND LIFE PARTNER 131 SOUTHFIELD RD. , CLEN BURNIE, MD 21060 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it any Injury or conce. tXX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Special BAYVIEW CREMATORY INC. JAN. 7, 2009 | BALTIMORE MD 22 FINK TUNERAL HOME, P.A. re of Funeral Service FINK CKX GOR M01148 426 CRAIN HWY, S. GLEN BURNIE, MD 23a. Part L Enter the disease, or a shock or heart failure. List of omblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumoulo disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any heading to him ellate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s page certificate 2 No 1 ☐Yes 2 ☐ No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After th funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after use.... To the Funeral Director: Af investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier tive, 2009 MANNIN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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			Registrar 1. Decedent's Name (First, Middle	. Last)		Cei	lineale of	Dealii		Reg.	No. L		3. Time of Death
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1/2	/Medic Examir		4a. Facility Name (If not institution				4b. City, Town, o	or Location o			4c. County o		
			ST AGNES	HOSPI	TAC		BALT						
	Funeral Director		5. Social Security Number 218–12–0987	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. 89	last birthday) Yrs.	If Under 1 Year Months Days	If Under	Min. (N	te of Birth lonth, Day, Ye t. 27,		Coun	lace (State or Foreign try) yland
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	ns 23 musi	Funeral	8630 Wrights M	12, Was Dece	edent Ever in U	.S. 13.	Was Decedent of F	Hispanic Ori	gin? (Specify Y	es or No-	14. Race		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	1 ☐ Never Married 2 ☐ Marr 3 🛣 Widowed 4 ☐ Divorced	Armed For ied 1 ☐ Yes If Yes, Giv Year or D	2⊉No ve		lf Yes, specify Cub 1 □ Yes 2 2 No			, etc.)	Specify:	White, e	
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Mal	d 2 sh th and 7 Is n traur		Dana Hickey	nip (<i>type. Frint)</i>	Son		Wrights					. ,	,
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Ä	permit Depar Impor any ir		Y Sallo	MAN	4	F	ıneral Ho 530 Edmor	ome of	Catons	ville, Caton	Inc.	. MT	21228
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	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		SIS						- 1	2 DAYS
	Examiner				(or as a conseq		. (6)	LITIS					4 DAYS
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P.O.	at the by the	hy	9 ☐ Unknown							D. D	1		()
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	siclan: The law certificate has t irector, page 2 s			. 1						☐ Yes 21		□Yes	21 No
7	siclar certif	Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 MrNo	Haspital	Înpatient 2	ER/Outpatie	t 2000 Oth	har:	of Death (Che		<u>. Пон</u>	(0	<u></u>
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no	Th.	tio	1 Natural 5 ☐ Pendir 2 ☐ Accident investi	ig i .	nth, Day Year)	Injury		irk?]Yes 2□	No				
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inad 28e. Place	e of injury - At h ing, etc. (Speci	ome, farm, str	reet, factory, office		28f. Le	ocation (Stree lity or Town, S	t and Numbe itate)	er or Rura	l Route Number,
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	o the l	Medical	one) 29b. Signature and title of certifie		iner stated.		29c. Licens	se number		29d.	Date signed	(Month,	Day, Year)
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Registrar DHMH 17 Rev 1/2001 32. Registrar's Signature

JAN 0 9 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00292 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 01-05-2009 Salvatore M. Ingoglia 0124 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05–18–1918 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months Days 1**X** M 2□ F 90 214-18-6582 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No MD Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1507 Superior St 21078 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Yes 2 No 1 ☐ Never Married 2 X Married 'natural", or 1 ☐ Yes 2X No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Barber Self Employed permit. Pages 1 and 2 should be filed or Department of Health and Mental Hygid Important: If item 27 is marked other i any Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony Ingoglia Josephine Buccari 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony S. Ingoglia (Son) 1507 Superior St Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Bayview Crematory 01-09-2009 Baltimore, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Dar Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed the burial-transit Due to (or as a consequence of): physician Physician/Medical use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) o 9□Unknown requires that the 9 Unknown þ ٦ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Ś pe 1 Yes 2 No 3 Probably 4 Winknown Completed Record page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient Medical Certification: To 1 Tyes 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Deat 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending

1 Natural 2 Accident 5 Pending investigation

6 Could not be determined 3 ☐ Suicide 4 Homicide

29a. Certifier

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IRICHARA, 2606ATEWAY DRIVE, SUITE 21/22B, BELAIR, MD 21014 ANULHA

31. Date filed (Month, Day, Year) JAN 09 32. Registrar's Signature

Registrar

State

DHMH 17 Rev 1/2001

within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 00293 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** JONES 11:45 AM ASTHER JANUARY 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hopkins Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 245.26.9469 1 ☐ M 2 💢 F 93 Yrs. Months Days Hours ИC Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mentel Hygene. m 27 is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Baltimore Baltimore MD 1 □Yes 2XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 7032 Yataruba USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No if Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify if Yes, Give Year or Dates: Completed by 3 Vidowed 4 □ Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Factory Worker Tobacco 9th grade 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNK-Be ovd Paylor uvenia 19a. Informant's Name Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other trai once. J. Smith Clarice Daughter 7032 Yataruba Drive Baltinore MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 Removal from State 10/09 Roxboro, NC OLL 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Joughn C. Sment. Funeral Senice Oli Road Randall stown MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear dailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ANEURYSM **Physician** Ihoracic disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine g physician and state is the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy certificate 1□ Yes 2 No To the Hospital or Attending Physician: funeral director, Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No r 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturai 5 Pending investigation Injury after death. 1 □ Yes 2 □ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier. 29c. License number 29d. Date signed (Month, Day, Year) D52301 JANUARY 05, 2009

Registrar

JOHN HOPKINS HOSP: tal BALTIMORE, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARTINEZ

32. Registrar's

ELIZABETH

31. Date filed (Month, Day, Year)

JAN 0 9 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Mary and Teparement of Health and Mental Hygiene 00294 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7, 2009 12:40PM Elsie Jean Josselyn January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Future Care Cherrywood Reisterstown Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year **Funeral** Hours Days 1 □ M **X**X F Months Director -88-85 Jan. 20,1923West Virginia 288-20-2537 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any Injury or other traumatic events. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes ZXXVo Funeral Director Baltimore Reisterstown MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21136 U.S.A. 224 Sacred Heart Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, XXYes 2 □ N If Yes, Give Year or Dates: 2 No 1 □ Never Married 2 □ Married 1 ☐ Yes XXNo Specify. ≥ Specify: White 3 Widowed XX Divorced WW II Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Drugstore Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Haze**l** Wood Randolph Antill မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 224 Sacred Heart Lane, Reisterstown, MD21136 Mary E. Janney / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2XXC remation 3 ☐ Removal from State Metro Crematory Inc. 01/08/09 Baltimore, MD 4 ☐ Donation 5 ☐ 10ther (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature Juneral Service Licenses 11605 Reisterstown Rd. Owings mills, MD21117 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ascular Physician Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O. 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No of Vital 1 □ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: AN Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this nours after death.

neral Director: After this
filled in by the funeral d 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 037573

Registrar

State

30. Name and address of person who complet

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31. Date filed (Month, Day, Year)

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of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

			For State Registrar	State	e of Ma	aryland /	Depa / Cert	rtment ificate	of He of D	ealth a <i>eath</i>	nd M	ental Hy	gien Reg. N		009	00295
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	Examin	er	4a. Facility Name (If not instituti					4b. City, To			Death		40	c. Count	ty of Death	
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Maryland	2 should by and Menta Is marked aumatic ev	၉	19a. Informant's Name/Relation			1	9b. Mailin	g Address (S	Street ar	nd Numbe	r or Rura	i Route Num	ber, City	or Town	n, State, Zip	Code)
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	/Medic Examir		4a. Facility Name (If not institution, give street and	NSINGT	भार	b. City, Town, or	LTIM	ONE	4c. County o	-TIMONE
	Funeral Director		5. Social Security Number 215-05-5574 Usual Residence of Decedent	90	Yrs.	f Under 1 Year Months Days	Hours Min		1912	9. Birthplace (State or Foreign Country) Preservet, Chio
	he Marylan 8a-f show otified at	Director	MD Baltimore	10c. City, Tow Park	/ille	е				10d. Inside City Limits 1 ☐ Yes 2 X No
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8760, <	Physician / Medical Examiner Physician and dical Examiner	23a. Part. Enter the disease, or complications the shock, or heart failure. List only one cause of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due	n each line.	of): i'C of):	erryt andi				Initiaryal Batween Onset and Death ITMN S YEMNS	
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	1		30. Name and address of person who completed of FERNANDS DEL 6Mg o	MO		BAL	TIMEN	6	10 212	34
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Baltimore,	permit. Departm Importa any inju		21. Signature of Fune		1	AI	22. Name and Add March F 4300 Wa	ress of Facility					21215
			23a. Part 1. Enter the	disease, or com	plications that cause	d the death. Do n	ot enter the mode of d				re,	rid /	Approximate nterval Between
	Physician /Medical		Immediate Cause (Fi disease or condition resulting in death)		a. Hypo)		ARAIN 1	NJURY	,			,	DAYS
and it	Examiner			- 1	Due to (or as	a consequence of	TAM DO	VAAF				1	DAYS
Ę		Jer	Sequentially list condi if any, leading to imme	itions, ediate	b. Due to (or as	a consequence of	f):	on ge					
J	cuted nd ransit	Examiner	Sequentially list condificant, leading to immediate. Enter Underly Cause (Disease or injustrat initiated events	ury 1	c. MITA	HZ VA	TAM POI	E PLAC	EMEN	7		ſ)A4S
o,	e exe iian al urial-t		resulting in death) Las	st	Due to (or as	a consequence of	f):	,				N.	EARS
68760,	rificate be executed g physician and as the burial-transit	edical			d	DO cAn	01115					/	CAIZS
P.O. Box 6	Physician: The law requires that the death certificate has been signed by the attending Ir this certificate has been signed by the attending Ir all director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2 □ 1 9 □ Unknown	onths?		e of pregnancy 2 ∐ Fetal death at time of death	3 ☐ Ectopic pregnal 5 ☐ Other (specify)				23d. Date Mor	e of delivery	y Day Year
	that hed by deta		Part II. Other signific	ant conditions	contributing to death	out not resulting in	the underlying cause g	iven in Part I.	23e. Did	tobacco	use contri	ibute to the	cause of death?
rds	w requires t s been signe should be o	q p	ACUT	E 1	2ENAZ	FAL	LUKE		_ 1 🗆	Yes 2	2 □ No	3□ Proba	bly 4 Unknown
of Vital Records,	he law red te has bee age 2 shou	Completed by							peri	opsy formed?	q b	rior to com eath?	sy findings available pletion of cause of
ital	an: T	BeC	25. Was case referred	d to medical				26. Place of [1 Yes Death (Check only		0 1	□Yes 2	I IID QIO
f \	nysici nis ce direc		exammer? 1 Xes 2 □ N	0	Hospital: 1 inpat	ient 2 ER/Ou	patient 3 DOA	ther: 4 \(\sime\) Nursin	g Home 5 ☐ Res	sidence	6 □Othe	er (Specify)	
o uo	ng ffe	tion:	27. Manner of Death 1 Natural 2 Accident	5 ☐ Pending investigation	28a. Date of In (Month, D	ury ay, Yea <i>r)</i> 28b. T	jury W	ury at ork? □Yes 2 □No	28d. Describe	how inju	iry occurre	ed	
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	28e. Place of In	jury - At home, far tc. <i>(Specify)</i>	m, street, factory, office)	28f. Location City or To	(Street a own, Stai	nd Numbe te)	er or Rural	Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a. Certifier 1 (Check only 2 one)	Certifying Pl	nysiclan: To the bes niner: On the basis and manner s	of examination an	death occurred at the	time, date and pl	ace, and due to the	e cause((s) and ma	nner as sta and due to t	ated. the cause(s)
	within To the compl	Me	29b. Signature and tit	le of certifier	ex!	1.0		nse number			-	(Month, D	
	1		Heat	hey R.	Skeihl	eld in) HD	6633	35	Ji	ANUA	24 8	05, 2009
	it		30. Name and addres	s operson who		/ ATT - N	Type, Print)			(-	- 0	4	05, 2009 NORE M
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	Sta Registr		31. Date filed (Morith,	9 2009	Senson.	trar's Signature	te!						21201

	1	For State Registrar	ype or Prir State of Ma		d / Depa	artme	nt of H		•		• • • • •	
Physiciar /Medica		1. Decedent's Name (First, Middle, Last) Sophie A. Kalinsk	i						2. Date of D Month Januar	eath Da	y Ye a	3. Time of Death
Examine Funeral	ı	4a. Facility Name (If not institution, give : Future Care Cantor 5. Social Security Number 6. Sex	n Harbor	e (In yrs.	last birthday)	Ba.	Ltimo	r Location of Death TE If Under 24 Hrs. Hours Min.	8. Date of B	irth	N/A	
Director works		195–20–1622 Usual Residence of Decedent 10a. State 10b. County		81 10c. Cit	Yrs. y, Town or Lo				08/16	/192	7 Pe	ennsylvania
with the Mar		Maryland N/A 10e. Street and Number		Bal	ltimore	10f. Z	ip Code			_	tizen of What (
urs a	Dy Lu	2105 Bank Street 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☐ Y If Yes, Give Ye ar or Dates:			Was Dec	1231 edent of Hecify Cuba 2∑No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No Rican, etc.)		Black, Wh	nerican Indian,
ithin 72 ho ine. han "natur i Medical	naiadilloa	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation co <i>mpleted)</i> College (1-4or 5	+)		kind of w DO NOT	ork done use retired	pation during most of word d)	king		(ind of Busines	s/Industry
permit. Pages 1 and 2 should be filed within Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, ITs Mone.		12 17. Father's Name (First, Middle, Last) Edward Skursky			Homer	nakei	r	18. Mother's Nam			Mestic Surname)	
and 2 should I lealth and Men m 27 is marke	-	19a. Informant's Name/Relationship (Ty				_		and Number or Ru	ral Route Num	-		
t. Pages 1 tment of H tant: If iten		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		Sac	Place of Dispo emetery, crer Cred He Ceme	sition (N natory or eart eter	ame of other place of J	esus 01/0	Date 06/2009	Bal	ocation - City o	
		23a. Feath . Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	X	the death	4(01 S	. Che		eet Bal	timo		yland 21231 Approximate Interval Between Onset and Death
Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as			oma 1	with	<u>Metastas:</u>	is			
be pur jeicié	EXG	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as									
The law requires that the death certificate is the has been signed by the attending physic bage 2 should be detached for use as the bage 2.	riiysiciali/iviedical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	I death 3	∃Ectopic ∃Other (pregnanc	y			23d. Date of d Month	lelivery Day Year
res the signe be d	2	Part II. Other significant conditions cor	ntributing to death be	ut not resu	ulting in the u	nderlying	cause giv	en in Part I.				to the cause of death? Probably 4 X Unknown
	completed	25. Was case referred to medical							perl 1 □ Yes	opsy formed? 2 X No	prior to death	autopsy findings available o completion of cause of ? s 2 □No
S Si S	2	examiner?	lospital: 1 ☐ Inpatie 28a. Date of Inju (Month, Da	ry	ER/Outpatier 28b. Time of Injury		28c. Injur Wor	4 Nursing H	ome 5 Res	sidence		pecify)
To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.	ury - At ho	ome, farm, str	eet, facto	ory, office		28f. Location City or To	(Street a own, Stat	nd Number or i	Rural Route Number,
the Hospital thin 24 hours a the Funeral I mpletely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physics Certifying Physics Certifier 2 Medical Examination Certifier	sician: To the best ner: On the basis o and manner sta	f examina	wledge, deat ition and/or in	vestigati	ed at the tion, in my o	ppinion, death occu	e, and due to the erred at the time	e, date ar	d place, and d	ue to the cause(s)
7 wit		00.	mplated cause of d	eath /lto-	n 23a) /T:]	R1258				uary 6,	nth, Day, Year) 2009
State Registra		Anne L. Villanueva 31. Date filed (Month, Day, Year) JAN 0 9 2009		,		•	Ste 2	00, Reist	terstow	a, Ma	aryland	21136

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00299 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month Gladys Alvenia Loy 8, 2009 January 11:04 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore <u>Greater Baltimore Medical</u> Center Towson If Under 24 Hrs. 7. Age (In yrs. last birthday) 92 yrs. 8. Date of Birth (Month, Day, Year) Sept. 14, 1916 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖰 F Hours Harrisburg, PA. 221-18-3825 **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore County Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 122 Glenmoore Road 21030 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 24∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leo Raymond Solada Ethel Irene Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 Mr.Russell R. Loy 122 Glenmoore Road Cockeysville, Maryland Health Department of Health important: If Item 27 any injury or other tr 27 Baltimorė, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages Darlington Cemetery Darlington, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Peace Funeral Cremation Ctr. P.A. 2325 York Road Timonium, Maryland 21093, P.A. 21. Signature of Funeral Service Licensee 23a. Part J. Enter the liseas of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should or mart illure. Jist only one cause the each line. Immediate Cause (Final Physician COMPUCATION OF FRACTURE OF HUMERUS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burlaf-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending properties for use as SE IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O.1 signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by Dementin 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy his certificate his director, page perform 1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death | Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Yes 2 □ No Certification: To After the 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 | Natural 5 ☐ Pending investigation Fell while welting, Unwithrested thin 24 hours after death.
the Funeral Director: A mpletely filled in by the fu death. 1 ☐ Yes 2 No 2 Accident UNKNOW December 23 2008 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Home/ ASSISTED LIVING FARILY 1414 FRONTST, LUTHERVILLE MO *Esertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) leed w JANUARY 8 2009 17 58 303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TUWSON 21204 CHARVES w 6701 N. Charles ST 31. Date filed (Month, Day, -Year) 32. Registrar's Signature State Registrar

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enyally

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 00300 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Little Jr. Hoover 13:30 M 01 01 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Ukn 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex Funeral 1 X M 2 □ F Director 61 47 NC 08 28 Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show traumatic event, the Medical Exeminer must be notified at Director 1 ☐ Yes 2 No Washington WD NA 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20011 U.S.A. #4 4828 New Hampshire Ave NW Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo δ, Specify: Specify: 3 Widowed 4X Divorced Black "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Photographer 4vrs+ 2th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental and Menta Mariam Sanders Harlee Hoover Little Sr. Pages 1 and 2 should nent of Health and Mer ည 19a. Informant's Name/Relationship (Type. Print) 4828 New Hampshire Ave NW #14, Washington, DC 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau Kobi Little-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Inc 1/7/09 Baltimore, Md Metro Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 21215 V 4300 Wabash Ave, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. After this certificate has been signed by the a funeral director, page 2 should be detached it 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Be Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 □ No 1 ☐ Yes 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No the within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) akomar Dark 7600 38 Registrar's Signature 31. Date filed (Month Day, Year) State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
amend Item 20c per fh 888/1-9-09 vt
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1 - State Registrar 0.03011. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Month Day Ha **Physician** 10:30AM Baskerville Lancaster January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Randallstown Seasons Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10 26 1 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 ☑ M 2 ☐ F 10 229-09-7886 10 VA **Director** 98 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Pikesville Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 21208 U.S.A. 3702 Seven Mile Lane Apt A-4 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, If a Pe Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 🔏 No 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify: Specify: Black ð 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) 12th grade Public Schools Educator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mariah Baskerville George C. Lancaster ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3702 Seven Mile Lnae, Apt A-4, Pikesyille Martha Lancaster-Wife 20c. Location - City or Town, State
Richmond, Virginia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/10/09 Calvary 4 🗖 Donation 5 ☐ Other (Specify) 21. Si man re of Funeral Service Licensee 22. Name and Address of Eacility
March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Palt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a END STAGE ALZITETMENS DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to him edictionable. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician end the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year ed by the a detached f 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 № No 24a. Was an certificate has birector, page 2 st autopsy 1 □Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Bother (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Date of Injury (Month, Day, Year) After th 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ad Burton m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Debrach I Burton 2835 Smith Ave Suk 203 Baltimore MD 21209 31. Date filed (Month, Day, Year) 32. Reg State Correcta Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 Tina LeSage **Physician** January 6, 10:05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert 7. Age (In yrs. last birthday) 62 vre If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/15/1946 6. Sex Birthplace (State or Foreign
Country) **Funeral** 5_Social Security Numbe 578-60-5505 Days 1 M 2 X F Washington D.C. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show be notified at 10a State 10h County MD Calvert Huntingtown 1 ☐ Yes 2 Ho Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 4240 20639 Baden Drive USA ral", or items 23a Examiner must b Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 "natural", or White 1 ☐ Yes 2X No Specify Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: the Medical Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 7 Is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Ross Isabelle Conner ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Alfred LeSage / Husband 4240 Baden Drive, Huntingtown, MD 20639 Department of Health Important: If Item 27 any injury or other trong once. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/8/2009 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall
22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner MADNIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and sthe burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 1 Live birth 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has e 2 s autopsy page certificate 1∐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Mbnth, Day, Year) 29b. Signature and title of certifier License number 1002718 2009

Registra DHMH 17 Rev 1/2001 0604

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

YOUSAF

JAN 09 2009

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 00303 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Da JAN 7, 2009 Day 1400 DERONG LIANG 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST NURSING HOME TOWSON BALTIMORE If Under 1 Year Months Days If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min. 1 🔀 💥 2 🗆 F Hours 65 JUNE 4, CHINA 220.37.5025 1943 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 🛠 № No PERRY HALL MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9504 MIDARO CT. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② YON If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No Specify Specify: CHINESE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COOK RESTAURANT unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON 9504 MIDARO CT., PERRY HALL, MD 21236 DONG LIANG 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State GLEN HAVEN CEMETERY JAN 10, 2009 GLEN BURNIE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service L 22. Name and Address of Facility FINK FUNERAL HOME, P.A. CREGORY 426 CRAIN HWY. S. CLEN BURNIE, MD 21061 23a. Part Enter the disease, shock or heart failure. L Approximate Interval Between Onset and Death remplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tony one cause on each line. RECTAL Immediate Cause (Final MONTHS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗖 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probabiy 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 ther (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner Ö Vital Physician: of or Attending Division Hospital within 2

funeral director, page 2 should this death 24 hours after deatle Funeral Director: filled in by the completely

Physician

/Medical

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Certification: To

Medical

29a. Certifier

(Check only one)

Examiner

Funeral

Director

If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Madical Exprinent refronts to mother at

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If Item 27 Is marked other i any Injury or other traumatic event, It

Physician

/Medical

Pages 1 and 2 should be 1 nent of Health and Mental

Baltimore,

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with the Maryland

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State

Registrar

29b. Signature and title of cer

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NCHARLES ST, SUITE 209 BALTIMORE, MD 21204 MAN, MO

MO 6565 32. Registrar's Signature 31. Date filed (Month, Day, Year)

ORIGINAL

	1 - For State Registrar			ertificate				eg. No.	2009	
Physician /Medical	1. Decedent's Name (First, Middle, La Richard	Miller					2. Date of Deat Month January	Day	Year 2009	3. Time of Death 4:55pm M
Examiner	4a. Facility Name (If not institution, give			4b. City,		r Location of Death		4c. C	ounty of Death	
آم	7405 Village Ro	ad Apt. 27				kesville				Carroll
Funeral Director	-07 22 0102	Sex 7. Age (In 7. Age	yrs. last birthday	Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 3,	1929	Cour	place (State or Foreign htry) PA
show	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or L	ocation					1	0d. Inside City Limits
Ba-f s	MD Carı	coll	Sy	kesvi1						1 Yes 2 No
be filed within 72 hours after death with the Maryland tall Hygiene. The Weddeal Evaluation must be notified at event, the Medical Evaluation must be notified at Be Completed by Funeral Director	7405 Village Roa	ad Apt. 27		10f. Zip		784	1	0g. Citize	en of What Coun USA	-
items items	11. Marital Status 1 ☐ Never Married 2 【 Married	12. Was Decedent Ever Armed Forces? 1 N Yes 2 No	in U.S. 13	. Was Deced If Yes, spec	ent of H ify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14	1. Race - Americ Black, White, e	
ral", or	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 19	51-52	1 ☐Yes 2	No No	Specify:		S	Specify: Wh	ite
be filed within 72 hou that Hygiene. ad other than "nature event, the Medical E	15. Decedent's E (Specify only highest gr		ı (Giv	edent's Usua e kind of wor DO NOT us	k done i	durina most of work	ing	16b. Kind	d of Business/Inc	dustry
La yearly Carlor 2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Manaumatic Be Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	l l	deral		,		US	Governm	ent
d othe event,	17. Father's Name (First, Middle, Last					18. Mother's Name			urname)	
d 2 should but and Men 7 is market traumatic		ller				Li11		ers		
nd 2 st ilth an 27 is r r traur	19a. Informant's Name/Relationship Mr. Craig Miller	(Son)		-		and Number or Rur ke Court		-		*
item item	20a. Method of Disposition	20	Ob. Place of Disp cemetery, cr					-	ation - City or To	
t. Page rtment tant: If	1 ☐ Burial 2 🂢 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	fy) A	11 Coun	ty Cre	mat:	ion 1/7/	I .	-	sville,	MD
permit. Pages 1 and 2 s Department of Health an Important: If them 27 is, any injury or other trau	21. Signature of Funeral Service Lice	11 11 11	2769	22. Name and HAIGHT PO Box	Addre FUI 1 Q	ss of Facility NERAL HOM 5 Sykesvi	E & CHAF	EL,	PA	
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	·wy								Approximate Interval Between
Physician	Immediate Cause (Final disease or condition resulting in death)	a. Cors	(cone	ath						Onset and Death
/Medical Examiner	Tooling in double	Due to (or as a cor	nsequence of)	fr 1)	chus	ian S	. 8.	-0	
iner in a	Secuentially list consider if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a cor	nsequence of):	troot	100	Louis)	120		
executed in and ital-transit	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a cor	sequence of):							_
tificate be executed physician and as the burial-transit		d								
y ≨ psg _e	IF FEMALE:									-
eath cert attendin for use a	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr 1 Live birth 2 4 Pregnant at time	Fetal death 3	☐ Ectopic pr		у		23	d. Date of delive Month	ery Day Year
The law requires that the death cer are has been signed by the attendinage 2 should be detached for use completed by Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	, or death 3	□ Office (spe	-ciiy)					
res tha signed be def	Part II. Other significant conditions	contributing to death but no	t resulting in the	underlying ca	use giv	en in Part I.				ne cause of death?
w requires the sign of the sig								s 2 🗆	No 3 Prob	pably 4 Unknown
The law requires the law requires the law been spage 2 should completed							24a. Was a autops perfori	nęd?	prior to cor death?	psy findings available mpletion of cause of
ician: The certificate ector, pag	25. Was case referred to medical					26. Place of Deat		e)	1 🗆 Yes	2 □ No
Physician: r this certific ral director,	examiner? 1 ☐ Yes 2 ② No	Hospital: 1 ☐ Inpatient	2 ER/Outpati	ent 3 🗆 DO	A Oth		me 5 Reside		☐ Other (Specifi	······································
the me in the indicate in the	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, Yea	28b. Time Injury	[]	Bc. Injur Worl	ry at k?	28d. Describe ho			2
Attending r death. ector: After by the fune	2 Accident investigation 3 Suicide 6 Could not be		At home farm s	M treet factory		Yes 2 □ No	28f. Location (Si	reet and	Number or Pure	I Poute Number
tal or Attending for standing for all Director: After ed in by the funer.	4 Homicide determined	28e. Place of Injury - building, etc. (Si	pecify)	aroot, lactory,	Cilioo		City or Town	n, State)	Number of Hura	r Houte Wantber,
To the Hospital or Attach. within 24 hours after death. To the Funeral Director: A completely filled in by the fu	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the best of my miner: On the basis of exa and manner stated.	knowledge, de mination and/or	ath occurred a investigation,	at the til	me, date and place, opinion, death occur	and due to the cred at the time, d	ause(s) a ate and p	and manner as s place, and due to	stated. the cause(s)
To the within common to the the the the the the the the the the	29b. Signature and title of certifier	()		29c	Licens	e number	2	9d. Date	signed (Manth,	Day, Year)
, h	30 Name and address of research	Completed source of the	(Itom 00-) (T	Deleth	7-	54105	1100		10910)
10	30. Name and address of person who	A SIMMO	8096	9 Li	où n	Rayort	31vd 5	Sit	Pro Pro	MARIA
State	31. Date filed (Month, Day, Year)	3. Registrar's S	Signature					-41.14	10	11
Registrar		19 Kenus	14. 140	A PROPERTY OF						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Please Type of Frint III Diack III.

Amend #7, per Fh e887 1/16/09 TT

Amend #17 Per FH G887 1/27/09 JH

Certificate of Death

Reg. No. 1 - For State Registrar Reg. No. 2009 00305 2. Date of Death 1. Decedent's Name (First, Middle, Last) JANUARY 2009 **Physician** 6:36 P M Helen Virginia Moody /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 10-01-1933 9. Birthplace (State or Foreign Country) MD 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 21 F Months 75 MD 76 Director 214-30-3343 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2X No Director MD Harford Bel Air e filed within 72 hours after death with the ! at Hyglene. other than "natural", or items 23a or 28a-10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1407 Bonnet Place Unit E 21015 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ∐Yes 2 X No Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: þ White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Inportant: If item 27 is marked oth any linjury or other traumatic event ODG. 17. Father's Name (First Middle Last) Be David B. Evans Ruth Grimes ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2723 Primrose Lane East York, PA 17402 Dawn Litke (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Bayview Crematory 01-06-2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servi 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc. 610 W. MacPhail Rd Bel air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEFSIS /Medical Due to (or as a consequence of): **Examiner** CARDIOMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ē The law requires that the death certificate be executed Exami MYOCARDIAL INFARCTION attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🔲 Ectopic pregnancy Month Dav Year 5 Other (specify) P.0. cate has been signed by the page 2 should be detached 9 Unknown 9 I Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>۾</u> 2 No 1 Tes 3 Probably 4 Unknown Completed CORONARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an END STACE RENAL DISEASE autopsy certificate 1 ☐ Yes 2 No 2**X** No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA this To the Hospital or Attending Provithin 24 hours after death.

To the Funeral Director: After the completely filled in by the funera 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 □ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig D24034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON, MARYLAND LOW. M. D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JAN 0 9 2009

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician VERNON A. MARTIN JAN 06, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, AUG 26, 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Hours Months 1**X** M 2 □ F 80 Director 220.22.3482 death with the Maryland 10c. City, Town or Location 10a. State 10b. County in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director MD ANNE ARUNDEL FERNDALE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 505 OAKLEIGH RD. 21061 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after all Hygiene. other than "natural", or iter 1, Yes 2 ☐ If Ves, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 ☐ Yes 2 🕅 🐪o Baltimore, Maryland 21215-0036 Specify. Specify: þ 3 ☐ Widowed 4√ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ROUTE SALESMAN F00D other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be. Department of Health and Mental I. Important: If flem 27 Is markmany injury or other? Be 2 EDNA CATHERINE DULANY JULIUS PETER MARTIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON VERNON R. MARTIN 926 OLD COUNTY RD., SEVERNA PARK, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State BAYVIEW CREMATORY, INC JAN 7,2009 BALTIMORE, MD 4 Donation 5 Dother (Specify) of Funeral Service Licer 22. Name and Address of Facility TNK FUNERAL HOME, P.A. CRECOPY 426 CRAIN HWY. S., CLEN BURNIE, MD lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Enter the discase, or cor ar heart fail re. List on y Due (or as a Immediate Cause (Final **Physician** Re disease or condition resulting in death) /Medical nce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner that initiated events resulting in death) Last use as the burlal-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No Completed 24a. Was an page 2 s autopsy performed certificate To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 1 Natural

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number 00057635 MO.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

29d. Date signed (Month, Day, Year) 2009 4 m

0905

10d. Inside City Limits

Approximate Interval Between Onset and Death

3 Probably 4 ☐ Unknown

1 ☐ Yes 2 XNo

Birthplace (State or Foreign Country)

USA

Black, White, etc.

WHITE

Nord 31. Date filed (Month, Day, Year)

29a. Certifier

2 ☐ Accident

3 ☐ Suicide

4 Homicide

(Check only

2001 MO 32. Registrar's Signature Annali

State Registrar

Medical

DHMH 17 Rev 1/2001

veral Director: A filled in by the fu

within 24 hours a

completely

		1 - For State of Maryland Department of Health at Certificate of Death	ńd Mental Hygiene Reg. No 2009 00307
Dhari		1. Decedent's Name (First, Middle, Last)	Date of Death Month Day Year 3. Time of Death
Physic /Med		T 1- M 4-4	January 5, 2009 11:35 A ^M
Exam	iner		
F	7	Casey House 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Montgomery 4 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
Funera Directo		133-09-1786 1X M 2 F 89 Yrs. Months Days Hours	4 Hrs. 8. Date of Birth (Month, Day, Year) Jun. 30, 1919 Sirthplace (State or Foreign Country) New York
pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location	
faryla f shov	5	,	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
the N	Director	MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
h with	10 Te	3416 Island Creek Court 20906	USA
death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican,	
15, INCL YIGHTOLE IN INCLUDED. 1 and 2 should be filed within 72 hours after death with the Maryland F Health and Mental Hygiene. 1 marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Evolument by notified at	2	3 ☑ Widowed 4 ☐ Divorced If Yes, Give WWII 1 ☐ Yes 2 ☑ No Specify:	Puerto Rican, etc.) Black, White, etc. Specify: White
72 ho	eted	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of life. DO NOT use retired)	of working
vithin sine.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 10 Self Employed—Cater	
filled v Hygic			ring Hall Food Service 's Name (First, Middle, Maiden Surname)
fental ked c	To Be		elina Cirabisi
and 2 should be filed within 7 salth and Mental Hygiene. n 27 is marked other than " ier traumatic event, Its Mer			r or Rural Route Number, City or Town, State, Zip Code)
t and 2 Health Hem 27 i		Angela Bruno / Daughter 11800 Hayfield Ct.,	
int of F		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
permit. Pages 1 and Department of Heal Important: If item 2 any injury or other	-ú		-10-2009 Westbury, NY James Romanelli-Stpehen Funeral
Depart	olog	Home, 89-01 Roc	kaway Blvd., Ozone Park, NY 11416
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as c shock, or heart failure. List only one cause on each line.	cardiac or respiratory arrest, Approximate Interval Between Onset and Death
Physiciar /Medica		Immediate Cause (Final disease or condition resulting in death) a. Sepsis	
Examine	_	Due to (or as a consequence of):	
sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discost of Figure 1) that initiated events c.	
ficate be executed physician and the burial-transit	edical Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):	
e be e	463	d	
rtifical ng phy as th			
ath ce	Jue /	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1	23d. Date of delivery Month Day Year
t the de	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 5 ☐ Other (specify)	World Day 18th
us, ruires that signed I	2	C—Difficile Colitic	23e. Did tobacco use contribute to the cause of death?
requi	eted	D 1 D 11	1 Yes 2 No 3 Probably 4 Unknown
he law e has	Completed	Renal Failure	24a. Was an autopsy findings available prior to completion of cause of death?
lan: T	Be C		1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No of Death (Check only one)
hysici nis ce	10 B		sing Home 5 ☐ Residence 6 【XOther (Specify) HOSPice
ling Pl	i i	27. Manner of Death 1 X Natural 28a. Date of Injury 28b. Time of Injury at Work? (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
Vitteno death ctor: y the	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number,
talor/ safter al Dire	Certification:	4 Homicide determined building, etc. (Specify)	City or Town, State)
To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical		
To th Within To th Comp	Me		29d. Date signed (Month, Day, Year) 2009
		Avenere W/Mlley SC. m. D0064615	January 5, 2008
.70	/	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Wroblewski, MD, 6001 Muncaster Mill Roa	ad Rockwille MD
S	State	31, Date filed (Month, Day, Year) 32, Registrar's Signature	M, RUCKVILLE, FID
Regis	strar	JAN 0 9 2009 Buch S. Jakes	

			- FOI	State of Marylan					nd Mei			000	00308	
		2	1 - State Registrer 1. Decedent's Name (First, Middle, Last)		Cel	tificate	e or L	Jeath	2	Date of Dea		009	3. Time of Death	_
-2	Physici		Floyd Edward Mask	e. Jr.						Month anuar	Day	2009 Year	11:44 A M	
	/Medic Examin	_	4a. Facility Name (If not institution, give sa			4b. City, T	Town, or	Location of		andaz		County of Dear		_
*		200	Sunrise of Freder	ick		Fred	lerio				F	rederio	2k	
T	Funeral		5. Social Security Number 6. Sex 113	7. Age (In yrs. 91	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2	4 Hrs. 8. Min.	Date of Birt (Month, Da uly 31	h y, Year)	9. Bird Ol Wes	thplace (State or Foreign buntry) t Virginia)
4.	Director		Usual Residence of Decedent	91					J	шту эт	., 13	717 wes	t virginia	
	how	_	10a. State 10b. County	10c. Cit	y, Town or Lo	cation							10d. Inside City Limits	
	8a-f	Directo	Maryland Montgomer	y Dai	nascus						10 011		1 ☐ Yes 2 ☑ No	_
	with ti	Dir	10e. Street and Number			10f. Zip	872				-	zen of What Co	•	
	Jeath The 23	Funeral	24711 Ridge Road 11. Marital Status	2. Was Decedent Ever in U	S. 13. V			spanic Origi	in? (Specif	y Yes or No		ed Stat	erican Indian,	_
326	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of heelth and Mental Hygiene. Department of heelth and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Exercipar ministic a notified at once.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give 1944-1 Year or Dates:	946	fYes, speci 1 ☐ Yes 2		n, Mexican, Specify:	Puerto Ric	an, etc.)		Black, Whit Specify: Wh		
Maryland 21215-0036	r2 hou	ted	15. Decedent's Educ		16a. Deced	dent's Usual	l Occupa	ition	of working		16b. Kir	nd of Business	/Industry	_
21	ithin 7 99.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)				furing most (٠.			
21	iled w tygier her th		8 17. Father's Name (First, Middle, Last)		Main	itenan	ice k	lepair	-	First, Middle,		vil Ser	rvice	
auc	d be fi) Be	Floyd E. Maske, S	r.					a Cri		Maidell	Surrame)		
2	should nd Me mark	ို	19a. Informant's Name/Relationship (Typ		19b. Mailin	ng Address	(Street a				er, City or	Town, State,	Zip Code)	- 2
Ĕ	and 2 elth a 127 ls		Floyd E. Maske, I	II/Son	2471	1 Rid	ge R	Road,	Damas	scus,	Mary	land 20	872	
ore	of He of He of item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20b. F	lace of Dispo emetery, crer	sition (Nam natory or oti	ne of ther place	e) Ja	Date anuary	12	20c. Lo	cation - City or	Town, State	Ī
Baltimore,	. Pag tment tant: I		4 ☐ Donation 5 ☐ Other (Specify)	Par	klawn Me			20	009				Maryland	
Bal	Departing Important in any in		21. Signature of Euneral Service License	M0154	.8 Ro 30	bert A. 0 West	d Addres Pump Monte	onrey Fu comery A	neral Avenue	Home/Rockv	ockvi ille,	lle, Inc. Maryland	20850	1
*	Physician		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	e cause on each fine.			e of dying	g, such as c	ardiac or re	aspiratory ai	rrest,		Approximate Interval Between Onset and Death	
Μ.	/Medical		disease or condition resulting in death)	End Stage P Due to (or as a conseq		OHS							yrs	_
	Examiner		Sequentially list conditions, b.	Prostate Ca									yrs	
	sit s	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or se a conseq		, ,								
P.	xecut end al-tran	хап	that initiated events resulting in death) Last	Dementia wi		y boa	ıes				_		yrs	
760,0 9,	ate be executed hysicien end the burial-transit	calE	d	Hypertensio	n with	Atri	al F	ibril	latio	n			yrs	
9	ntificating ph)	_	IS SENALS											
Вох	death certifical e attending phy id for use es th	lan/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1□Live birth 2□Feta	Ideath 3	Ectopic pre					2	23d. Date of de Month	livery Day Year	
0.	0 0 0	Physician/Med	1 Yes 2 No	4 □ Pregnant at time of d 9 □ Unknown	eath 5□	Other (spe	ecify)					14104101	Juy , ou	
<u> </u>	The law requires that the ste has been signed by the page 2 should be detache	y Ph	Part II. Dther significant conditions conf	tributing to death but not res	ulting in the u	nderlying ca	use give	en in Part I.		23e. Did to	obacco u	se contribute to	the cause of death?	
rds	w requires been sign should be	ed by	Immobility Syndro	me, Recurrent	Pneum	onia,				1 🗆 1	Yes 2[□No 3□Pi	robably 4 🛣 Unknown	
ဝင္ပ	e law re has bee	plet	Asthma							24a. Was		24b. Were at	utopsy findings available completion of cause of	
ř	The sete ha	Completed								perfo	rmed?	death?	2 🔯 No	
Vita	Attending Physicien: The I r death. ector: After this certificete ha by the funeral director, page	Be	25. Was case referred to medical examiner?	ospital:			0.5	26. Place	of Death (C	Check only o	пе)	As	sisted	
ō	Phys r this ral dir	5 1	1 ☐ Yes 2 🔀 No	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatien 28b. Time of					5 Resid			sist of city)Living	
O	nding Phi th. : After thi s funeral	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	м	Bc. Injury Work	(?` Yes 2∐N				, 555555		
Division of Vital Records,	or Atter efter dea Director in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory,	, office		28f	Location (S City or Tox			ural Route Number,	
	To the Hospitel or Attendi within 24 hours etter death. To the Funerel Director: A completely filled in by the fu	edical Co	29a Certifier X Certifying Physic (Check only one) 2 Medical Examin	ician. To the best of my knower: On the basis of examina and manner stated.	wladge, daat! tion and/or in	vestigation,	in my op	e, date and pinion, death	plana and occurred	due to the at the time,	causa(s) date and	and harmed di place, and due	stated. e to the cause(s)	j
	vithin ; o the	Med	29b. Signature and wife of testifier	and manner stated.	1	29c.	License	number			29d. Dat	e signed (Mont	h, Day, Year)	
)	->-0		· allen K	willy.	MI	ī	D547	49			Janı	iary 8,	2009	
	ax		30. Name and address of person who con	mpleted cause of ath (Item	n 23a) (Type,						- 0.110			
	11,		J. Allen Reilly, N				nue,	Suite	e Dl,	Frede	erick	, Mary	land 21701	1
16	Sta Registr		31. Date filed (Month, Dey, Year)	32. Registrar's Signe	ture	Kal								

DHMH 17 Rev 1/2001

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		chols, III State	of Maryland / Departn Certifi	cate of				eg. No. 2	009	9 0030
Physici Medical Exam		Decedent's Name (First, Middle, Last				76 1	2. Date of Deat Month	Day Ye.		Time of Death
/ LX		Roland Law 1 4a. Facility Name (if not institution, give	rence Nichols estreet and number)	11	1 b. City, Town, or	Location of Dea	January 5	4c. County	of Death	11021110
		341 Gatewater Court Apt :	204		Glen Burnie			Anne A		
Funeral Director		5. Social Security Number 6. Se 218-68-3424 1 X		oirthday) 52 Yrs.	If Under 1 Year Months Day		in.	h(MM/DD/YYY)	Y) 9. Birthp Foreign Count	
		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	vn or Location	on				T1	0d. Inside City Limits
nd show a		Maryland Anne A	rundel		Gle	en Burni	e ·			Yes 2 X No
e Maryland or 28a-f show any	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	hat Country	/?
th the 23a or		341 Gatewater Co				21060			USA	
imore, MD 21215-0036 [Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyghee. The singular of the filed within "and the filed "and the file of the filed had not or other transmatic event, the Nedic-I Examiner must be notified at once	/ Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 V Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year	If Ye	Decedent of Hises, specify Cubar	, Mexican, Puer	Specify Yes or No to Rican, etc.)		te, etc.	n Indian, Black,
ours a	d by	15. Decedent's Education (Specify on	Lor Dates:	a. Decedent	's Usual Occupa	tion (Give kind o		16b. Kind of Bi	usiness/Ind	ustry
36 in 72 h han "n Jic 1 E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	dumig me	Chef	. DO NOT use i	etired)	Rest	aurar	.+
21215-0036 und be filed within 7 I Mental Hygiene, marked other than ic event, the Medic	팅	17. Father's Name (First, Middle, Last)	l		1	18.Mother's Nar	me (First, Middle, I	1		
1218 1 be fill ental H arked	a		Vichols 11			Barbar		thman		······································
MD 2 et 2 should lith and M n 27 is m	٤	19a. Informant's Name/Relationship (Ty Roland L. Nichols	· · · · · · · · · · · · · · · · · · ·	_			r Rural Route Num irt, Pasa			
e, N Land 2 Health Item 2		20a. Method of Disposition	_		tion (Name of ce	metery,	Date	20c. Location		
MOF Pages nent of nent: If		Burial 2 X Cremation 3 Donation 5 Other Specify:	Tremoval Irom State		matory I	nc. Ja	an. 12 2009	Baltim	ore,	Maryland
Baltimore, MD 21215-003 permit, Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If Item 27 is marked other in injury or other tranmatic event, the Men		21. Signatur of Funeral Service Licens	ee Malling	22. N	ame and Address	of Facility Intain R		gs Fune adena,	ral H MD 21	ome, P.A. 122
Physician /Medical		23a. Part I. Enter the disease, or complete failure. List only one cause on ea	ch line.			such as cardiad	or respiratory arr	est, shock, or he	eart	Approximate Interval Between Onset and
`xaminer		The state of the s	Atherosclerotic Cardiovasc Due to (or as a consequence of):	cular Dise	ease		_		-	Death
		Sequentially list conditions, b.								
	nine	cause. Litter Universiting Cause	Due to (or as a consequence of):							
50, te be executed sysician and burial - transit	el Examiner	(Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence of):	,						
O, e be exe /sician a	ledical	UNPENDED	AMENDED							
876 tificate ng phy as the l	٤	#F FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnand		al death 3	Ectopic preg	nancy	23d. Date o Month	of delivery Day	y Year
Box 6876 re death certificate the attending phy red for use as the	/sician/M	1 Yes 2 No 9 Unknown	4 Pregnant at time of death	5 Oth	ner (Specify)			Ì		
cords, P.O. Box 6876 law requires that the death certificat has been signed by the attending ph 2 should be detached for use as the	Phys	Part II. Other significant conditions	9 Unknown contributing to death but not result	ting in the u	nderlying cause	given in Part I.	23e. Did to	bacco use cont	nbute to the	e cause of death?
Division of Vital Records, P.O. tat or Attending Physician: The law requires that the Indicate and Director: After this certificate has been signed by ted in by the funeral director, page 2 should be detact	d by						1 1 Yes	2 No 3	✓ Probab	oly 4 Unknown
ords v requi	Completed						24a. Was autop			psy findings available inpletion of cause of
tal Reco cian: The law certificate has	E E				**		perfo	rmed? 2No	death? ✓ Yes	2 No
tal F cian: certifi ector,	8	25. Was case referred to medical examiner?	ospital:			of Death (Chec		•		
of Viting Physic After this	입	1 ✓ Yes 2 No 27. Manner of Death	i inpatient 2 ER	Outpatient b. Time of In		Other Nur	sing Home 5	Residence 6 how injury occur		Scene
ON C ending ath. or: Aft	Certification:	1 Natural 5 Pending	(Month, Day,Year)			Yes 2 No		,,		
IVISIOR or Attene after death Director:	<u>ii</u>	2 Accident Investigation 3 Suicide 6 Could not be	28e Place of Injury - At home	, farm, stree	t, factory, office t	ouilding, etc.	28f. Location (S		ber or Rura	Route Number, City
Di spital hours a neral I	 	4 Homicide determined	(opcoy)							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only Certifying Physici	an: To the best of my knowledge, of the basis of examination and/o							
To To com	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		29d. Date sign	ned (Month	n, Day, Year)
		(Kanlerk	celle!)		O.C.	M.E.		January 6	, 2009	
1)		30. Name and address of person who could be seen a color MD			Street Dali	more MD C	1201			
				Penn	Street, Baltir	nore, MD 2	1201			
	tate	 Date filed (Month, Day, Year) 	32. Registrar's Signature	part	b					

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death $\text{J}_{an}^{\text{Month}}$ ^{Day} 2009 Year **Physician** 7 Walter J. Newbauer Sr. 7:07 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Essex 930 Homberg Avenue 8. Date of Birth
(Month, Day, Year)
(Acch 11, 1927 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** XXM 2□ F 219-22-5428 OHTO Director 81 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modeal Examiner must be notified at Baltimore Essex MD 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 USA 930 Homberg Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2√□No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Lever Brothers Electrician 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Marion Klasen John J. Newbauer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 930 Homberg Avenue Baltimore MD 21221 Carolyn Newbauer /wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 Removal from State Holly Hill Cemetery 1/10/09 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Freeral Service Ly 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** moli ac disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760. attending physician for use as the burial The law requires that the death certificate be evolemia Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death signed by the a 1 □Yes 2 □ No o 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ZING 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) t Yes 2 No Hospital: Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) Certification: To After this al or Attending Phy s after death. Il Director: After this od in by the funeral d 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a

To the Funeral D the Hospital Medical Detifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 50184C Q L 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ala RUD 15 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year John Stewart Newman /Medical January 2009 7:15 P 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**XX**M 2□ F Director 161-20-0590 4, 1927 Maryland Usual Residence of Decedent should be filed within 72 hours after death with the Maryland of Mental Hygiene.
marked other than "natural", or items 23a or 28a-f show 10a State show 10b. County 10c. City, Town or Location ar than "natural", or items 23a or 28a-f show 10d. Inside City Limits Director 1 ☐ Yes 2XXXVo Maryland Carroll Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 4554 Wentz Road, P.O. 246 by Funeral 21102 of America 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married XX Married altimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: 3 Widowed 4 Divorced Year or Dates Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) President Banking ortant: If item 27 is marked other injury or other traumatic event, 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be 1 ment of Health and Mental Wilmer Bailey Newman Mabel Irene Bankert permit. Pages 1 and 2 shoul Department of Health and Mi Important: If item 27 is marl any Injury or other traumatl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jane Newman P.O. Box 246, Manchester, Maryland 21102 20a. Method of Disposition

20a. Method of Disposition

3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 10, 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) Rest Haven Cemetery 2009 Hanover, Pennsylvania 21. Signature of Funeral Service Licenses 22. Name and Address of Facility. Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** -HRONIC OBSTRUCTIVE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending philor use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy signed by the a d be detached for Day Year 1 ☐Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1. Yes 2 No 3 Probably 4 Unknown has 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 No 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Math 28b. Time of or Attending 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury death. within 24 hours after death To the Funeral Director: 2 Accident 1 ☐ Yes 2 No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO1663 30. Name and address of person with completed cause of death (frem 53a) of the Point) WESTMINSTER 447 EAS

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 20:55 M orraine 01 05 200 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bayview Medical Baltimore Johns Hopkins lenter If Under 1 Year | If Under 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Days 1 ☐ M 2 🖫 F 220-03-8210 Director 25,192 July Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits 28a-f shov traumatic event, the Medical Evan instruments be notified at Baltimore MD Completed by Funeral Director Baltimore 1 ☐Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 8005 E. Baltimore Street 21224 items 23a USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 🔀 No Specify: White 3 K Widowed 4 □ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "na any Injury or other traumatic event once." Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anthony Raab Catherine Beck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn Evans /niece 7407 Alvah Avenue Baltimore MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Oak Lawn Cemetery 1/9/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore MD 21. Signature of Funeral Service License 22. Name and Address of Facility 300 Mace Ave. Balto. MD olle Connelly Funeral Home of Essex 23a. Part 1 Enter the disease, or amplication that caused the abath. shock, or heart failure. List only one course on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician YDOXIA /Medical Due to (or as a consequence of **Examiner** estive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to lo as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 🗌 No 3 Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 **N**0 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident within 24 hours after death To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed/(Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amanda Tiffany Lathiq, MD 4940 Eastern Avenue, Baltimore, MD

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Walter R. O'Neil 2009 January 10:40 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Min Months 1 X M 2 □ F 065-28-7768 73 Oct. 1935 13, Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2X No Maryland Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5215 King Charles Way 20814 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No If Yes, Give Year or Dates: 1955-57 Specify: Specify: White 3 ☐ Widowed 4 K Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Fireman Fire Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas E. O'Neil Lillian Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas J. O'Neil/Brother 145-72nd St., Apt. Bl, Brooklyn, New York 11209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State January 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium Bethesda, Maryland 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home, Bethesda—Chevy Chase, Inc. 21. Signature of Funeral Service Licenses Willian phils M01173 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lung Cancer disease or condition resulting in death) Due to (or as a consequence of): Pneumonia Due to (or as a consequence of): Cardiac Arrest Due to (or as a consequence of): Respiratory Failure 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 N Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Weight Loss 24a. Was an autopsy performed? Yes 2 🖾 No Malnutrition 1 □ Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1∐ Yes 2 🗓 No Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Department of Health and Mental Important: If Item 27 is marked o any injury or other traumatic eve

Pages 1

Physician

Examiner

Funeral

Director

28a-f show

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death

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Baltimore, Maryland 21215-0036

Box 68760,

P.O. I

Records.

Division of Vital

death.

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2009

Director

Funeral

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Completed

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traumatic event, the Medical Examiner must be notified at

/Medical

physician and s the burial-trans attending p been signed by the should be detached page 2 s

Examine Physician/Medical ģ Completed certificate has Be After this Certification: To funeral I Director: A filled in by after

27. Manner of Death

1 X Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifier

within 24 hours a Medical State Registrar

Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cachexia

> 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 5 Pending investigation

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

> 29c. License number D0065182

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

January 2, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Old Georgetown Road, Bethesda, Maryland Zenuz Sima Nourani, M.D.

31. Date filed (Month, Day, Year) -

6 ☐ Could not be

determined

32. Registrar's Signature parker

			For State Registrar	State of Mar	•	epartment <i>Certificate</i>					09	00314
	Physicia		1. Decedent's Name (First, Middle,	Last)	4	Pe+;++			2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, To	own, or Locati			4c. County of	of Death	
	Funeral Director		5. Social Security Number 220-12-6997 Usual Residence of Decedent	S. Sex 7. Age 1 X M 2 □ F	(In yrs. last birt	hday) If Under 1 Months /rs.	Year If Un Days Hou	ider 24 Hrs. R	B. Date of Birt (Month, Da 01/22	th y, Year) 2/1925	Cou	place (State or Foreign ntry) Hill, MD
Marviand	-f show	tor	10a. State 10b. County	imore	10c. City, Town						1	10d. Inside City Limits 1 □ Yes 2 X No
with the	Sa or 28a Lbe noti	l Direc	10e. Street and Number 1117 B. Old E	lastern Ave	enne	10f. Zip C	ode 221			10g. Citizen of W	/	ntry?
fally all d Z LZ L 3-0030 should be filed within 72 hours after death with the Maryland	to Health and Mental Hygene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. Was Decede If Yes, specifi 1 □ Yes 2	nt of Hispanic y Cuban, Mex		ify Yes or No- ican, etc.)	- 14. Race Black		
U-C 1 2 1 2	giene. r than "natur the Medicul I	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 1 2	Education grade completed) College (1-4or 5+	,	Decedent's Usual (Give kind of work life. DO NOT use ainter	Occupation done during r retired)	most of working	7	16b. Kind of Bus		*
yidhe file	Mental Hy arked othe atic event,	To Be C	17. Father's Name (First, Middle, La David I. Peti					other's Name (Maiden Surname Riley	?)	
, Mar.	# 22 T		19a. Informant's Name/Relationshi			Mailing Address (,
1) _	Department of Her important: if Item any injury or othe once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Control Cont		20b. Place of cemeter Morel Parl		5rãal		9/09	Parkvi	Lle,	MD
	Depart import any inj		21. Signature of Funeral Service Li	censee ACU	Z.	22. Name and Evans I 8800 Ha	Address of Fa Funera arford	acility al Cha d Rd.	pel & Parkv	Cremat	 :ian 1D 21	Services 234
1	hysician /Medical xaminer		231. Part. Enter the in ease, or c shick, or heart milure. List of imm diate Cause (Final disease or condition resulting in death)	omplications that caused to niy one cause on each line a. Due to (or as a	Asc	LV	of dying, such	h as cardiac or	respiratory ar	rrest,		Approximate Interval Between Onset and Death
Ę		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Divease or injury that initiated events resulting in death) Last	b								
The law requires that the death certificate he executed	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 Live birth 2 4 Pregnant at 9 Unknown	∑ Fetal death	3 ☐ Ectopic pre 5 ☐ Other (spec				23d. Date Mor		rery Day Year
ecords, r.	n signed build be deta		Part II. Other significant condition	s contributing to death but	not resulting in	the underlying cau	ise given in Pa	art I.			ibute to t	the cause of death?
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OI VILAI	this certifi	To Be	25. Was case referred to medical examiner? Yes 2 □ No	Hospital: 1 ☐ Inpatien		tpatient 3 DOA	Other: 4	Place of Death(<i>ne)</i> dence 6 □Othe	∍r (Speci	ify)
DIVISION OF the Hospital or Attending	death. ctor: After y the funera	Certification: To	27. Manner of Death Natural 5 Pending Accident investiga 3 Suicide 6 Could no	ot be 280 Place of Injur	Year) li	ime of pjury M	c. Injury at Work? 1 ☐ Yes 2	2 🗆 No		now injury occurre Street and Number		al Route Number
DIV	within 24 hours after death. To the Funeral Director: A completely filled in by the funeral properties of the funeral pro		4 ☐ Homicide determing determine determing determing determine de	building, etc. Physician: To the best of	(Specify)				City or Tou	vn, State)		
o the Ho	vithin 24 h	Medical	(Check only one) 2 Medical E	xamîner: On the basis of and manner stat	examination an	d/or investigation, i	n my opinion, License numb	, death occurre	d at the time,	date and place, a	and due t	to the cause(s)
	14		30. Name and address of person w	the completed cause of de	oth (Itam 23a)		७० (इ.			JANHA	124	6,2009 D21230
	Sta	ato.	30. Name and address of person was a series o	the completed cause of de	ARAN	1 6000	Sa	nant	en Ho	fital	M	021230
	Registr		JAN 0 9 200	19 Lenson	r's Signature	a Not				·		

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09-00177 Brodis Peterkin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 00315

		I- For State Registrar		Certificate	e of	Death			R	eg. No.		0001
Physicia ledical Exami	in/ ner	1. Decedent's Name (First, Middle, Brodis Pet	erkin					1 1	Date of Dea Month anuary 6	Day Year		ne of Death 140 hrs
		 Facility Name (if not institution, Johns Hopkins Hospital)	4	b. City, Town, or Baltimore	Location of	Death		4c. County of	Death /a	
Funeral Director		5. Social Security Number 6 2 1 7 8 4 - 2 3 2 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	l l	ge (In yrs. last birthda 73	Yrs.	If Under 1 Year Months Days		24Hrs. 8 Min.		th(MM/DD/YYYY) 3,1935	Foreign	S.C.
th with the Maryland ems 23a or 28a-f show any t be notified at once.	Funeral Director	10a. State	12. Was Deceder	it Ever in U.S. 1	alt	timore 10f. Zip Code 21202 s Decedent of Hisses, specify Cuban	panic Origii		y Yes or No	0g. Citizen of Wha USA 14. Race - White,	1 X	inside City Limits Yes 2 No
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once	ompleted by		y only highest grade co	No /52 - 2 /7 / / / / / / / / / / / / / / / / /	1/-5 cedent	Yes 2 X No 's Usual Occupat ost of working life.	specify: ion (Give ki DO NOT u man	ind of work ise retired)	done	Specify: 16b. Kind of Bus Bear Maiden Surname)		
21215. 21215. Duld be filed I Mental Hy, marked of	To Be C	Donny Robinso	o (Type, Print)			Address (Stree	Ora	Pet per or Rura	erki	n nber, City or Town		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		Broadus H. Ro 20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other Spe 21. Schature of Funeral Service Li	3 Removal from/s	20b. Place of E crematory Garri	or oth SOI	tion (Name of cer per place) I Fores ame and Address IVIN B.	of Eacility	an.l	6,20 Fun	alto, M 20c.Location - 9 Owin eral Ho alto.Md	gsMil me	State 1s,Md.
Physician /Medical xaminer	ler	23a. Part I. Enter the disease, or creatile failure. List only one cause of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	mplications that cause n each line. a. Atherosclerotic Due to (or as a con b. Due to (or as a con	c Cardiovascular sequence of):	nter th	ne mode of dying,	such as ca	rdiac or res	spiratory arr	est, shock, or hea	rt App	roximate Interval ween Onset and Death
xecuted	al Examiner	Clisease or injury that initiated events resulting in death) Last	C. Due to (or as a con	sequence of):								
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed releath. reter: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transi	by Physician/I	UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkn Part II. Other significant condition	1 Live birth 4 Pregnant a own 9 Unknown	ome of pregnancy at time of death 5	Oth	ner (Specify)	Ectopic		23e. Did t	23d. Date of of Month obacco use contrib	Day	use of death?
Division of Vital Records, tal or Attending Physician: The law requir is after death. al Director: After this certificate has been seled in by the funeral director, page 2 should t	e Completed	25. Was case referred to medical				26 Place	of Death (Check only	1 ✓ Yes	osy pr ormed? de		findings available tion of cause of
ion of Vita rending Physicia eath. ior: After this cer the funeral direct	To B	examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 ✓ Natural 5 Pendir 2 Accident Investi	28a. Date of In (Month, Day	ient 2 🗸 ER/Outp jury Year) 28b. Tin		3 DOA DOA 28c. Injury	Other	Nursing H	lome 5	Residence 6 how injury occurre	Other:	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could determ	not be 28e. Place of	Injury - At home, farm	ı, stree	et, factory, office b	uilding, etc	. 28	f. Location (or Town,	Street and Numbe State)	r or Rurai Ro	ute Number, City
Divi	Medical		sician: To the best of iner:On the basis of ex and manner stated	amination and/or inve			, death occ				e to the caus	
		30. Name and address of person w	tho completed cause of	death (Item 23a)		O.C.I		OCM	E	January 7, 2		9,,00,
341	ate	Theodore M. King, Jr., 131. Date filed (Month, Day, Year)	MD. Assistant	Medical Examin		111 Penn Str	eet, Balt	timore, N	MD 2120	1		
Regis		1881.0.0	Pa .	vas B. x	ha	Mal						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician EBUCK 200්9් January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carrol1 Carroll Hospice Dove House Westminster If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Hours Months 1√2 M 2□ F 219-66-3468 **Director** Nov 17 1953 Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location Sykesville MD Carroll Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6614 Freedom Avenue 21784 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white Specify ል 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland maintenance chief 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Joseph L. Roebuck Nannie Wilson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shelly Metts (daughter) 2222 Bullfrog Rd., Fairfield, PA 17320 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State Lake View Memorial 1 - 13 - 09Sykesville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityHaight Funeral Home & Chapel Parge Haight 3 P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each lin. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) attending physician P.O. Box 68760. Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 □ Yes 2 25. Was case referred to medical examiner? Be

Hospital

5 Pending investigation

6 □ Could not be

determined

28a. Date of Injury (Month, Day, Year)

on who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1:50a

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

6 Other (Specify)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

26. Place of Death (Check only one)

5 ☐ Residence

28d. Describe how injury occurred

Other: 4 \(\sum \) Nursing Home

Injury at Work?

1 ☐ Yes

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Probably 4 ☐ Unknown

Year

1 Tives 2 Tivo

Division of Vital Records, certificate this To the Funeral Director: completely filled in by the within 24 hours a

To the Funeral

> State Registrar

Certification: To

Medical

1 ☐ Yes

27. Mann of Death

1 Naturai Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier

30. Name and address of pera

Natural

DHMH 17 Rev 1/2001

555 SOUTH Center ST. Westminsty

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

			For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F ertificate of			giene Reg. No. 200	9 00317
	Physicia /Medic		1. Decedent's Name (First, Middle, Las	ebbert				2. Date of Dea Month	Day Ye	3. Time of Death
W. Salan		Examiner 4a. Facility Name (If not institution, give street and number)					r Location of Deat	h	4c. County of D	
			Oakcrest Care Cer				ville If Under 24 Hrs	T 0 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		imore
B	Funeral Director		5. Social Security Number 6. S 212-07-4460	977 M OF F	(In yrs. last birthday 91 Yrs.	Months Days	Hours Min.		1918	Birthplace (State or Foreign Country) MD
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Maryla rf sho	tor	MD Baltime	ore	Parkv					1 ∐Yes 2 🌠 No
-	h the or 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
,	23a c		8812 Walther Bl	vd #2217			234		USA	
336	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show he Mcdical Examinar rust be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:	ver in U.S. 13	Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 2 🏋 No	lispanic Origin? (\$ an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	- 14. Race - A Black, W Specify:	merican Indian, Thite, etc. White
2-0	be filed within 72 hours after death with the Marylan tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Mydical Examilyar mast be notified at	To Be Completed	15. Decedent's Ed	lucation de completed)	16a. Dec	edent's Usual Occup e kind of work done	pation during most of wo	rkina	16b. Kind of Busine	ess/Industry
Maryland 21215-0036			Elementary/Secondary (0-12)	College (1-4or 5-	·) life.	DO NOT use retire ager	d)	9	Steel In	ndustry
d 2	Hyg Hyg nt,		17. Father's Name (First, Middle, Last)			0			Maiden Surname)	
ylar	s 1 end 2 should be fi of Health and Mental I item 27 is marked of other traumatic evel		Adam Rebbert Christina Rosenberge							
Mar			19a. Informant's Name/Relationship (Diane Millhiser			ling Address (Street North Wat			er, City or Town, Stai J 07760	te, Zip Code)
re,	s 1 en of Hea item 2		20a. Method of Disposition		1	osition (Name of ematory or other place		Date	20c. Location - City	or Town, State
altimore,	permit. Peges 1 Department of H Important: If ite any Injury or ot once.		X☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		1			-06-2009	Baltimore	e, MD
Balt			21. Signature of Funeral Service Licer	Inada					Funeral F el Air, MI	Home of BelAir) 21014
ı			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death							
- 3	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	consequence of):	····				
	Examiner	ılner	Due to (or as a consequence of):							
	pe \ tis		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):						
	n end	Examine	that initiated events resulting in death) Last c			nce of):				
8760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician enderal director, page 2 should be detached for use as the burial-transit	Physician/Medical	•	d						
P.O. Box 68			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	☐ Ectopic pregnand	су		23d. Date of Month	delivery Day Year
			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown							
Records,	The law requir ate has been s age 2 should I	Completed by				***		24a. Was auto perfo	psy prior deat	e autopsy findings available to completion of cause of h? Yes 2 □ No
Vital	ysician: The is certificate hadirector, page	Medical Certification: To Be C	25. Was case referred to medical examiner?				26. Place of De	ath (Check only o		763 20110
of \	To the Hospital or Attending Physic within 24 hours after death. To the Funeral Director: After this or completely filled in by the funeral dire		1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred						
o			1 Natural 5 Pending 2 Accident investigation	(Month, Day	(Year) Zob. Time	Wo	rk?]Yes 2∐No	28d. Describe	how injury occurred	
Division			3 Suicide 6 Could not b determined	e 28e. Place of Injubuilding, etc	rry - At home, farm, s (Specify)	treet, factory, office		28f. Location (City or To	Street and Number o wn, State)	r Rural Route Number,
			29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
_	vithi To the		29b. Signature and title of Certifier			29c. Licen	se number		29d. Date signed (M	Ionth, Day, Year)
Chur MSW R171944								1/5/2009		
30. Name and address person who completed cause of death (Item 23a) (Type, Print), Michealle G Horrison Chil 8832 Walther Blvd, Parkville, Mo 2/234								2/234		
	Sta Regist		31. Date filed (Month, Day, Yelfr)	32. Registra	ar's Signature	no Klad				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 5,2009 **Physician** 12:25P Ronald B. Reed /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Balto. 4307 Silver Spring Road Perry Hall If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) August 5,1950 7. Age (In yrs. last birthday) **Funeral** Days Months 1 XM 2□ F Utah 58 August Director 554-78-2780 Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Exprinter must be notified at traumatic event, the 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 € No by Funeral Director Perry Hall Balto. Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21128 4307 Silver Spring Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No White Specify: 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Automotive Plant 12 4 Machinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lafan Lundberg John D. Reed ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once. 4307 Silver Spring Rd. Perry Hall, Md. 21128 Jean Reed Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-9-2009 Balto. City Bayview Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 9705 Belair Rd. Nottingham, Md. 21236 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Selfin Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this (28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending elfinflicted gun shot wound January 5,2009 1225 PM 1 ☐ Yes 2 X No ours after death.

neral Director: A death. investigation 2 ☐ Accident 3 Suicide 4 ☐ Homicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 30 7 5: Luan Spring Rd Perry Hall, Md 21236 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined tome , Md within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 86ble who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p CT. Lutherville Md ella 6 31. Date filed (Month, Day, Weld) 32. State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JAN **Physician** Doris Cecilia Randolph 2:05 AM 04 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Levindale Nursing Home Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 220-24-9847 1 M 2 X 80 Director 18, 1928 Maryland Sept. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant; If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notifiled at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No Maryland N/A Baltimore Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21201 474 Manse Court USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes — No Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Human Resources Interviewer 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert Butler <u>Gertrude Loadholt</u> ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tanya Williams/ Granddaughter748 Northrop Lane Middle River, Md 21220 Method of Disposition

1□ Burial 2 □ Cremation 3 □ Removal from State

1□ Donation 5 □ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

1 / 1

New Cathedral Cemetery 20c. Location - City or Town, State 1/10709 permit. Pages Department of Important: If It any injury or o Baltimore, Maryland 21. Signature of Fineral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 20% 5240 Reisterstown Rd Baltimore, Md 21215 23a. Part1. Enter the dis Ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail. e. List only one cause on each line. Immediate Cause (Final Physician tailure 4 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Amyloidosi months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner certificate be executed ng physician and as the burial-transil that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 50 Month 5 Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ End stage renal 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No autopsy performe certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 X Natural 2 ☐ Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No I or Attend after death Director: in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours afte To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Sepur. MD 01/04/2009 D0053928

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DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

, Day, Year) 32. Registrar's

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURALYA BEGUM, MD 2434 W. BELVEDERE AVENUE, BALTIMORE, MD - 21215

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Vear Physician 1:00 P M Ethel C. Reese January 5, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Charlestown Care Center Baltimore Catonsville If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 1 F Director 216-30-9539 April 1914 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1∩a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Howard Ellicott City 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9337 Joey Drive 21042 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify. Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Criminal Court 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles C. Councilman Barbara T. Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Reese <u>9337 Joey Drive; Ellicott City, MD 21042</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State New Cathedral Cemetery 1/8/2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Sign ture of uneral Service Licens 1630 Edmondson Avenue; Catonsville 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nstr Physician 1 ronic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a nonsequence of): Examiner The law requires that the death certificate be executed use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown been signed by should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has N autopsy performed page death? 1 ☐ Yes this certificate 2□ No or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ No 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 2 ☐ Accident 1 ☐ Yes 2 ☐ No after death filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ID 30. Name and addre of person who completed cause of death (Item 23a) (Type, Print) 10 Cu Maride (No u 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene -Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 5:55 AM Anthoni 01 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Sons Hospice andallstown Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** gyrs. 1**/2**M 2□ F Days Hours 214-38-324 Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Randallstown 1 ☐ Yes 2 Ko Director MD 10e. Street and Number 10g. Citizen of What Country? Sigrid Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Blac 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) duears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Marga 2 unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 3113 North Windsor, Milly MD 21244 Mont. Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 01-16-2009 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills Greene funeralsous 21. Signature of Funeral Service Licenses 22. Name and Address of Facility aux Kandallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End-Stage Liver Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physlcian: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ⊡ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 1 ☐Yes 2 ☐No 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 □ Residence 6 □Other (Specify) 1 ☐ Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To funeral 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 Pending investigation deeth. 4 hours after deeth. 1 TYes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MSKUJUPALNEMD

N.S. Rajapakse, MD

DHMH 17 Rev 1/2001

Darko

29c. License number

DOUS7465

h (Item 23a) (Type, Print) 25 Main St, suite 200, Reisterstown, MD 21136

29d. Date signed (Month, Day, Year)

1/4/09

and manner stated

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Leon Diehl Schoppert, Jr. January 2009 08:30 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford 121 Red Bud Road France I Year Hours Min. 8. Date of Birth May 1, 1930 6. Sex 1 M 2 □ F Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days 217-24-8610 78 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 □Yes 2 No Director Maryland Harford Edgewood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 121 Red Bud Road 21040 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 □ No 1951 -1 ☐ Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: White Specify: ģ 3 Widowed 4 Divorced 1953 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Operations Engineer Construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lean D. Schappert, Sr. Ethel Ruth McMullen ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rita G. Schoppert - Spouse 121 Red Bud Road, Etopewood, Maryland 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 1/10/2009 Parkville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services — Parkville 8800 Harford Road, Parkville, Maryland 21234 23a. Part 1. Enter the of sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fedure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) arterioschrotie Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 2 40 2 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

es that the death certificate be executed Division of Vital Records, P.O. Box 68760,

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Physician

/Medical

Examiner

Funeral

Director

TIS 23a or 28a-f show

th and Mental Hygiene.
7 is marked other than "natural", or items: traumatic event, the Modical Examination.

permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinations.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

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the Hospital or Attending Physician: The law requir	the Funeral Director: After this certificate has been s	apletely filled in by the funeral director, page 2 should
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29c. License number

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

1)2/02 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12 Rel

and manner stated.

State Registrar

29b. Signature and title of certifier

29a Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 9 1 9 00323 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death January 8 Day 200Š^{ear} Bessie Simon **Physician** 4:20p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Transitions Health Care Sykesville Carroll If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (S Country) Sept 20 1917 unknown Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🖫 F 159-12-6371 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mentai Hygiene.
Item 27 ie marked other then "naturat", or itema 23a or 28a-1 show other traumatic event, the Macical Examinational to profitte and Sykesville MD Carroll 1 ☐ Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 7309 Second Avenue 21784 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No tf Yes, Give 1 ☐ Yes 2 No Specify: White Specify: tf Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) unknown unknown unknown 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 125 Stoner Ave., Westminster, MD 21157 Gail Jones (guardian) 20a. Method of Disposition
14☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Springfield Cemetery 1-9-09 20c. Location - City or Town, State permit. Pages 1
Depertment of HImportant: if ites
any injury or oth Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Daige Spaight Sperbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final Macroglobulinemia **Physician** Waldenstrom disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physicien and hed for use es the burial-transit be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2√No 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifics 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4. Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 ☐ € 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1/2 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Ptace of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O.

Box 68760,

Baltimore, Maryland 21215-0036



State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AHMOUD 31. Date filed (Month, Day, Year)

29b. Signature and title of pertifier

JAH 0 0 2000

Registrar DHMH 17 Rev 1/2001 29c. License number

29d. Date signed (Month, Day, Year)

09-00136 C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

harlene Sweeny	State of Maryland / Department 1-For State		ene Reg. No. O O O O O O O					
Physician/	1. Decedent's Name (First, Middle,Last)	2.[Date of Death 3.7 ime of Death					
Medical Examine	Charlene Sweeney 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Month Day Year 2044 hrs anuary 5, 2009 2044 hrs					
	Franklin Square Hospital Center	Rosedale Baltimore County						
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2XF 62	Marcha Dave House Min	Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) OH					
any	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Lo.	cation	10d. Inside City Limits					
<u> </u>	MD Baltimore Midd	lle River	1 Yes 2 X No					
3440 the Maryland 23a or 28a-f sho autified at once.	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?					
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f she r transmatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		21220 Was Decedent of Hispanic Origin? (Specif	V Yes or No- 14. Race - American Indian, Black,					
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica		,	rst, Middle, Maiden Surname)					
21215-Culd be filed vomental Hygimarked oth		Louisa Bo	ural Route Number, City or Town, State, Zip Code)					
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Baltimore, MD openii Pages I and 2 sho pepartment of Health and Important: If item 27 is injury or other traumati	1 X Burial 2 Cremation 3 Removal from State crematory of	r other place)						
Baltimore permit Pages I Department of H Important: If in injury or other	4 Bollation 5 Other Specify.	Name and Address of Escility	9-2008 Fallston, MD					
Ba Perm Depa Injur	Al Ille	Schir Inc. 610 W. MacPhai	nunek Funeral Home of BelAir L Rd BelAir, MD 21014					
Physician /Medical	23 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death							
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tal Reco	25. Was case referred to medical 20.Place of Death (Check only only)							
of Viling Physic	examiner? 1 V Yes 2 No Place Hospital: Inpatient 2 V ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred							
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Division os spiral or Attending to rours after death. Brend Director: After filled in by the fune of the filled in by the fune of the filled in the fune of the f	2 Accident Investigation 3 Suicide 6 X Could not be found in	street, factory, office building, etc. 28	8f. Location (Street and Number or Rural Route Number, City or Town, State) 408 Grovethorn Rd Middle River, MD					
ospital hours a	Tomore							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 burns after death. To the Panneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitional Certification: To Be Completed by Physician/Madical Ex	(Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)							
5 ± 5 0 0		29c. License number	29d. Date signed (Month, Day, Year)					
	Carol Hallan	O.C.M.E.	January 6, 2009					
(10)	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Per	nn Street, Baltimore, MD 21201						
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 00325 State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year : 4:22p. Sanders Sr. 2009 01 D. 06 Eric 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Randallstown 3806 Offutt Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year Min 1 X M 2 □ F 08 63 45 216-92-3997 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 □Yes 2X No Randallstwon Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21133 3806 Offutt Road 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ∐Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Black 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Baltimore City of Public Elementary/Secondary (0-12) Dept. College (1-4or 5+) Truck Driver 12th grade Works 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sylvia Johnson Vernon B. Sanders Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3806 Offutt Road, Randallstown, Md 21133 Donna Sanders-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory Inc 1/12/09 Baltimore, 22. Name and Address of Facility
March F/H West ature of Funeral Service Licensee 21215 4300 Wabash Ave, Baltimore, 23a. Part 1. Enter the lisease, or complications that caused the death. shock, or heart tailure. List only one cause on each line. Approximate Interval Betwe Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 X No 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 □Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 28d. Describe how injury occurred

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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21. Sig

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Weden Examination of the forms 1 by the context once.

24 hours after death Funeral Director: filled in by

Examiner Physician/Medical ģ Completed Be Certification: To

23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 Unknown 25. Was case referred to medical examiner? 1 ☐ Yes 27. Manner of Death

28a. Date of Injury (Month, Day, Year) 28b. Time of 5 ☐ Pending investigation

28c. Injury at Work? 1 ☐Yes 2 ☐No М

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated

6 ☐ Could not be

determined

29c. License number 773

650 ORLEANS ST, BALTIMORE

29d. Date signed (Month, Day, Year)

0

Registrar

death.

within 2.

31. Date filed (Month, Day, Year) State

1 Natural

2 Accident

3 Suicide

29a. Certifie

Medical

4 Homicide

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day Year 07:06 AM llan 2009 Jan 07 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner AGNES HOSPITAL Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Gountry) 6. Sex Date of Birth (Month, Day, **Funeral** Hours 1□ M 217 F Days Min. 213-26-596 Usual Residence of Decedent Director 15911119 al Hygiene. . other than "natural", or items 23a or 28a-f show vent, the Medical Exeminer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 □ No imore 10g. Citizen of What Country? 10e. Street and Number within 72 hours after death . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 III No Specify. 3 ¥Widowed 4 ☐ Divorced Blace 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If item 27 is marked other t. any Injury or other traumatic event, I'n once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ohnnie 19a. Informant's Name/Relationship (Type. Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licenses Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shoot or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 8 days **Physician** Hypoglycemia /Medical Due to (or as a consequence of): Examiner Diabetes Mellitus lears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 ☐ Other (specify) has been signed by the 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary rtherosclerosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? page 1 ☐ Yes 2 ☑ No 1 ☐ Yes 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

Baltimore, Maryland 21215-0036

Box 68760,

Records,

Vital

Division

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAHMOUD ALDANDASHI

JAN 09 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

900

32. Registrar's Signature

29c. License number

Cation Ave,

2065

29d. Date signed (Month, Day, Year)

Baltimore, MD 21229

Jan, 07, 2009

_			For State Registrar	State of Mar		epartmen Certificate				Reg. No		09	00327
	Physici /Medic		Decedent's Name (First, Middle, Lass Lillian Georgia						2. Date of De Month 01	eath Da	ay 2.00	Year	3. Time of Death 04:15 AMM
	Examir		4a. Facility Name (If not institution, give Gilchrist Cente 5. Social Security Number 6. S	e street and number) r ex 7. Age ((In yrs. last birtl	'[l'O	wson 1 Year	If Under 24 Hrs.	nd		Balt	imor	place (State or Foreign
	Director		216-36-6467 Usual Residence of Decedent	□ M 2 🔀 F	100 Y	rs. Months	Days	Hours Min.	08/28/	1908	3	Mar	yland
115	Maryland -f show ied at	tor	10a. State 10b. County MD Baltimo		10c. City, Town							1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
0	vith the	Director	10e. Street and Number		Glen	10f. Zip					itizen of W		ntry?
000	death v	Funeral	12627 Manor Road	12. Was Decedent Eve Armed Forces?	er in U.S.		ent of His	spanic Origin? (S n, Mexican, Puert	pecify Yes or N			- Americ	can Indian,
1/7/0	hours after death with the Maryland tural", or items 23a or 28a-f show at Examiner must be notified at	δ	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ∐Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2			o nican, etc.)		Specify:	white, e	
) (215-0	72 na	Completed	15. Decedent's Ec (Specify only highest gra	ducation ade completed) College (1-4or 5+)		Decedent's Usua (Give kind of wor life. DO NOT us	il Occupa k done di e retired)	ition uring most of wor	king	16b. I	Kind of Bus	iness/Ind	dustry
ims and 21	filed wif Hygien other th		8 17. Father's Name (First, Middle, Last)		<u> </u>	omemakir		18. Mother's Nar	ne (First, Middle		OWN E		
A Simis Maryland 2121	should be a ind Mental imarked o imartic eve	To Be	John Brandenburg		-			Pertie					
Mar	id 2 sho Ith and 27 is m		19a. Informant's Name/Relationship (,	-		,	nd Number or Ru					<i>'</i>
ίω nore,	Pages 1 and nent of Health ant: If item 27 ary or other tr		Linda M. Pittac 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of cemetery	Disposition (Nan , crematory or ot	ne of ther place	9)	Date	20c. l	_ocation - (City or To	
Lilli∟ Baltimore,	permit. P. Departme Importany any Injury once.		4 ☐ Donation 5 ☐ Other (Specifical Signature of Funeral Service Liber		Dulaney	22. Name an	d Addres	.Gd.01/1 s of Facility E r Road	F. Las	sahr	ı Fun	eral	Home, P.A.
			23a. Part1. Enter the disease or com shock, or heart failure. List only	plications that caused the		ot enter the mod					C, Fic	.r y rc	Approximate Interval Between Onset and Death
G	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a		ncer						-	months
	Examiner	er	Sequentially list conditions,	bDue to (or as a c	consequence o	f):						-	****
	ificate be executed g physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a c								-1	
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O. Box	eath certi attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								23d. Date Mor		ery Day Year
ds, P.	w requires that the dispension of the should be detached	þ	Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlying ca	ause give	n in Part I.					he cause of death?
Division of Vital Records,	e law req has beer le 2 shou	Completed								psy	l p	rior to co	opsy findings available impletion of cause of
taiF	Th ate pag	Be Cor	25. Was case referred to medical					26. Place of Dea	1 □ Yes	-		eath? □Yes	2 □ No
of Vi	Physician: r this certific ral director, i		examiner? 1 ☐ Yes 2 X No			patient 3 DC		r: 4 ☐ Nursing F	lome 5 ☐ Res	sidence			hospie
sion	Attending I r death. ector: After by the funer	ation	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		Year) 28b. Ti	jury M	8c. Injury Work' 1 □ Y	at ? ′es 2 □ No	28d. Describe	now inji	ary occurre	d	
Divis	Direct of the part	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		y - At home, far (Specify)	m, street, factory	, office		28f. Location City or To			r or Rura	al Route Number,
	e Hospital 24 hours e Funeral etely filled	edical (nysician: To the best of miner: On the basis of e and manner state	examination and								
	To the within 2 To the comple	Me	29b. Signature and title of certifier	S			License	3303		1	ate signed	(Month,	Day, Year) 2009
	X		30. Name and address of person who		(71	Type, Print)	Cero	rus ST	- Tuis	son	m	21	204
	Sta Registi		31. Date filed (Month, Day, Year)		's Signature	barker							

09-00180
Leonard Salters

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 00328 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day January 6, 2009 2100 hrs Medical Examiner eonarc 4b. City, Town, or Location of Death. c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year I If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Min. Davs Hours Director Country) 220-58-555C 1 LM 2 Yrs Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 1 Yes 2 No death with the Maryland Director 10g, Citizen of What Country? 10e. Street and Numbe 10f. Zin Code 0 main Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status White, etc. Armed Forces? Never Married 2 Married Yes 2 L No f Yes, Give Yea 2 No specify Specify: Wh Lovorced Yes 3 Widowed 4 l other than "natural", the Medical Examiner à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Baltimore, MD 21215-0036 pernit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. 19 a 1867 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ten 27 is marked traumatic event, (Be Andr Elizabeth eonarc 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Karen Her Jayeselle Dr. Marassas 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) or other Burial 2 Ucremation 3 Removal from State tant: Crementory etro Donation 5 Other Specify: 22. Name and Address of Family 21 Singeture of Funeral Service Licensee Midralley Dr. Jessup I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician ilure. List only one cause on each line. Between Onset and Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) dy events resulting in death) Last and transit Physician/Medical 23a,27,perME, g887 1/23/09 X UNPENDED ted by the attending physician detached for use as the burial the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IE EEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available has been page 2 should autopsy prior to completion of cause of performed? death? ✓ Yes 2 ✓ Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: 2 V ER/Outpatient DOA Nursing Home 5 Residence 6 Other Inpatient this 1 🗸 Yes 2 28a. Date of Injury (Month, Day,Year) 28c. Injury at Work? 28d. Describe how injury occurred After 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural Yes 2 death. Pending 2 Accident Investigation in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide determined within 24 hours a (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 2 🗸 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie O.C.M.E January 7, 2009 - JIMO 30. Name and address of person who completed cause of death (Item 23a) Obend 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

ORIGINAL

Registrar

IAN 0 9 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Ellenmarie Ann Shaw 4:48 PM /Medical 2009 Tanuary 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number 6. Sex Baltimore City
If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🖫 F Director 152-32-4623 66 Oct. 12, 1942 New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Modical Examinar mast be notified at Director 1 ☐ Yes 2 ☑ No Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 502 Ramblewood Drive 21009 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married ģ If Yes, Give Year or Dates 1 ☐ Yes 21 No Specify Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Associate Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe Paul Albert Shannon plnous ဂ္ Winifred Frances Scheckenbach Department of Health an Important if item 27 is many injury or other 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammi E. Sinosky / Daughter 3655 Marpat Drive, Abingdon, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Christian Ch. Cem. 1-9-09 Joppa, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Juneral Service Licensee 1(una 317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) New - ischemic Crolismyopsthy 3 reeks /Medical Due to (or as a consequence of): Examiner HEART FAILNE Sequentially list conditions, if any, leading to immediate cause. Lister Underlying Cause (Disease or injury that initiated events. Examiner Due to (or as a consequence of) requires that the death certificate be executed as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day Month Year 5 Other (specify) ed by the a 1 ☐Yes 2 ☐ No 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Chronic Obstachue Dumonum Disesse 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has 24a Was an page 2 The 2 No 1 ☐ Yes 1 Tyes 2 No Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this (1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural death. I Director: A 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Division of Vital Records, hours after within 24 hours a

To the Funeral C

completely filled To the Hospital

Maryland 21215-0036

Saltimore,

Box 68760,

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State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Yedr) -

(4 HD

29c. License number

401 West Belvedere Ave.

Baltimore, MD 21215-5217

RES-000

29d. Date signed (Month, Day, Year)

JANJ954 5 2009

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ramela Demisse MD Sinai Hospital of Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM 10f per INF, G887, 1716/09 WS
State of Maryland / Department of Health and Mental Hygiene O O O 00330 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Sean L) en15 Maurice. Jan 2009 1/20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Place 1LOCKUILLE Montromery 729 10/10 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Nov. 24 Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□F 37 Yrs. 212-86-9266 Nov. 1971 Washington, Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or itema 23a or 28a-f show injury or other traumatic event, the Medical Examinations must be notified at 1 ☐ Yes 2 No Maryland Montgomery Rockville Direct 10e. Street and Number 20850 20854 10g. Citizen of What Country? 1729 Yale Place United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No White Specify: þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nai any injury or other traumatic avantation." Elementary/Secondary (0-12) College (1-4or 5+) 12 Student College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) Be Gaston Pierre St. Denis Natalie Yeager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18330 Winter Park Court, Gaithersburg, MD 20879 Gaston Pierre St. Denis/father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition January 9, 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2009 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. Sutte M01548 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertengive /Medical Due to (or as a consequence of): Examiner bello Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last me Due to (or as a consequence of): Examine The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-transit Oivm's 5 Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medicai 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 1000428 mo Dms X 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRECHER MO DMK N 31. Date filed (Month, Day, Year)_ 32 Registrar's Signature State

Registrar

JAN 0 9 2009

09-00093 Andre Thorpe Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

re Thorpe		State of Maryland / Department o For State Certificate o	f Health and Mental Hygiene	2009 0033					
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of D						
dical Exami	-	Andre A. Thorpe, Jr.		4, 2009 Year 2256 hrs					
		Table (in the method of give a series)	4b. City, Town, or Location of Death Baltimore	4c. County of Death					
		Johns Hopkins Hospital 5 Social Security Number		n/a Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign					
Funeral Director		220 22 4580	Months Days Hours Min.	Country)					
Director		220 33 4309 1 M 2 F 17 Yr Usual Residence of Decedent	Nov	.14.1991 MD					
any	l	10a. State 10b. County 10c. City, Town or Loca	tion	10d. Inside City Limits					
ind show nce.	5	MD n/a Bal	timore	1					
Maryla 28a-f d at o	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?					
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f show any ent, the Medical Examiner must be notified at once.		813 N. Kenwood Avenue	21205 as Decedent of Hispanic Origin? (Specify Yes or	No- 14. Race - American Indian, Black,					
ath wir tems?	Funeral	1X Never Married 2 Married Armed Forces?	Yes, specify Cuban, Mexican, Puerto Rican, etc.)						
ter de ", or i		3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2X No specify:	Specify: Black					
ours af atural camin	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decede	ent's Usual Occupation (Give kind of work done most of working life. DO NOT use retired)	16b. Kind of Business/Industry					
6 n 72 h an "n ical E	lete	Elementary/Secondary (0-12) College (1-4 or 5+)		none					
within grene.	Completed	10th 10. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd						
1215-0036 d be filed within 72 fental Hygiene. narked other than '	Be C	Andre A. Thorpe, Sr.	Sherreice	Johnson					
ould a Mer	To		ng Address (Street and Number or Rural Route	Number, City or Town, State, Zip Code)					
MD 2 nd 2 shou alth and M m 27 is n		Sherreice Johnson (mother) 813	N. Kenwood Ave. Basition (Name of cemetery, Date	alto, Md. 21205					
nore, ages l ar nt of He t: If ite		1 Burial 2 Cremation 3 Removal from State crematory or c	other place)						
Baltimore, sermit. Pages 1 a Department of He Important: If ite injury or other t		A Abouting 5 Other Specific / Mt. Zio	n Cemetery Jan. 14, 2	2009 Baltimore, Md					
Baltimore permit. Pages 1 Department of P Important: If injury or other		27 Signature of Funeral Service Licensee	Name and Address of Facility Calvin B. Scruggs I	Funeral Home					
Physician	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	the mode of dying, such as cardiac or respirator	y arrest, snock, or Mean Approximate Interval Between Onset and					
'Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Gunshot Wound Of The Head		Death					
·		or condition resulting in death) Due to (or as a consequence of):							
	ıer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
nd uted A.	Ě	d							
) De exec Ician a	dical	UNPENDED							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attenting Physician: The law requires that the death certificate be executed within 24 hours after death. To the Functual Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year					
Box 68760 death certificate the attending physed for use as the b	iciar	past 12 months? 4 Pregnant at time of death 5	Other (Specify)						
Bo ne deat the at	hys	Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I 23e.	Did tobacco use contribute to the cause of death?					
of Vital Records, P.O. ing Physician: The law requires that th After this certificate has been signed by tuneral director, page 2 should be detach.	by F	Part II. Other significant conditions contributing to death but not resulting in th		Yes 2 No 3 Probably 4 Unknown					
ds, l equires een sig	Completed			Was an 24b. Were autopsy findings available prior to completion of cause of					
COF	nple			autopsy performed? death? Yes 2 No 1 ✓ Yes 2 No					
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/ital /siciar nis cer directo	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2 ER/Outpatie	ent 3 DOA Other Nursing Home	5 Residence 6 Other:					
Division of Vital Records, tal or Attending Physician: The law requires after death. Director: After this certificate has been siled in by the funeral director, page 2 should the control of the contro	ä	27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day, Year) 4737 here	Subject	cribe how injury occurred was shot					
tendi death.	Certification:	1 Property of the state of the	1 Yes 2 No	tion (Street and Number or Rural Route Number, City					
Division of Vipital or Attending Pluours after death. ceral Director: After tilled in by the funeral	Pending Investigation Investigation Investigation Solution Investigation								
Divisior Bospital or Attend 44 hours after death Funcral Director: stely filled in by the		29a. Certifier 1 Continue Physician: To the best of my knowledge death of	curred at the time, date and place, and due to the	e cause(s) and manner as stated.					
To the Hospital within 24 hours To the Funcral completely filler	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigant many many many many many many many many	gation, in my opinion, death occurred at the time,	date and place, and due to the cause(s)					
F.B.F.S	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)					
		Panat Grithall, MD	O.C.M.E.	January 5, 2009					
\		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner	111 Penn Street, Baltimore, MD 2120	01					
\	State	Tarrela E. Courtain, IVID							
	State	1 have	de l						

		1	For State Registrar	State of Maryland /	Department of Health and Certificate of Death		ene 2009	00332
	Physicia		1. Decedent's Name (First, Middle, Last)	Thomas	2. Date of Death Month JANUARY	Day දර්න්ර	3. Time of Death 4 : 55 F M
	/Medic Examin		4a. Facility Name (If not institution, give Saint Joseph 1	street and number) ledical Center	4b. City, Town, or Location of De		4c. County of Death Balti	more
	Funeral Director		5. Social Security Number 6. Se		oirthday) If Under 1 Year If Under 24 H Wre Months Days Hours M		(ear) 9. Birthpl 1913 Ball	ace (State or Foreign
e Maryland	itied at	ctor	10a. State 10b. County Boal H	more Pa	wn or Location KVIII C		10	od. Inside City Limits 1 ☐ Yes 2 No
th with the	23a or 28	al Director	8834 Victo	ry Ave.	10f. Zip Code 21234	100	g. Citizen of What Count U. S. A	ry?
d 21215-0036 filed within 72 hours after death with the Maryland	if Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Vas Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Ye ar or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 □Yes 2 🌠 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - America Black, White, e	
Maryland 21215-0036	giene. r than "natur Inc Medical	Completed	15. Decedent's Ed. (Specify only highest grad		a. Decedent's Usual Occupation (Give kind of work done during most of v life. DO NOT use retired) HOMEMAKE	vorking 16	Sb. Kind of Business/Ind	nome
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altimore, ermit. Pages 1 ar	Department of I Important: If ite any injury or or once.		1 ★ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify, 21. Sign ture 1 Funeral Service Licens	St.	of Disposition (Name of tery, crematory or other place) Stons Ous 22. Name and Address of Facility	8/09 1	Jundai K.	mD_
n 8	.õ ≞ to o		Immeriate Cause Final		o not enter the mode of dying, such as car		1.0	Approximate Interval Between Onset and Death
1	Medical xaminer		Jise se or condition resulting in death)	a. <u>FRIERIUSCLE</u> Due to (or as a consequenc		OLHK DISC	[**]) [
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I Records, P.O. Box 68760, The law requires that the death certificate be executed	/ the attending phy: ched for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 75 No 9 □ Unknown	a			23d. Date of delive Month	ry Day Year
'ds, P. uires that t	n signed by the aid be detached	ð	Part II. Other significant conditions of	ntributing to death but not resulting	in the underlying cause given in Part I.		acco use contribute to th	
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V ital sician: ⊺	certificate h rector, page	æ	25. Was case referred to medical examiner?	Hospital:	Othor	Death (Check only one)		
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Division of Vita Hospital or Attending Physician:	rs after death. al Director: Af led in by the ful	Certification: To	1 ♣ Natural 5 ☐ Pending investigation 3 ☐ Sulcide 6 ☐ Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	M 1 □Yes 2 □ No	28f. Location (Stre City or Town,	eet and Number or Rura State)	l Route Number,
Hospita	within 24 hours af To the Funeral D completely filled in	edical C			ge, death occurred at the time, date and pl and/or investigation, in my opinion, death o			
To th	within To th comp	Me	29b. Signature and title of certifier	1.	29c. License number	290	d. Date signed (Month, i	
	\wedge		mien-o	Ky mo	D31865		1-5-00	1
<u> </u>	7		30. Name and address of person who c			OWSON MA	RYLAND 21	2014
the office	Sta Registr		31. Date Tiled (Month, Day, Year)	32. Regiskar's Signature	of OSLER DRIVE, 1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 00333 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 o7 01 1940 PM Marilyn M. White 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Rosedale Baltimore Franklin Square Hospital Center 5. Social Security Number 6. Sex 7. Age (In y 7. Age (In yrs. last birthday) 74 yrs 8. Date of Birth (Month, Day, Year If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 1□M 2 🕇 F Months Days Hours 218-32-5425 Yrs Feb. 18, 1934 Tyrone, PA. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □Yes 2P¥No Maryland Baltimore County Middle River 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 18 Compass Road 21220 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify. White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Secretary Doctors Office 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Foster E. Miller Florence Sprangle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Floyd A. White (Husband) 18 Compass Road Middle River, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Jan.09, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel 2009 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify)

Physician /Medical **Examiner**

Physician

Examiner

10a. State

Funeral

Director

28a-f show

Director

Funeral

ģ

Completed

Be

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Important of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Marical Examiner must be notified at once.

altimore, Maryland 21215-0036

/Medical

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlah-transit completely filled in by the funeral director, page 2 should be detached for use as the burlah-transit Physician/Medical þ Completed Be Certification: To

Division of Vital Records, P.O. Box 68760,

or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Lenter the disease, or come, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

25. Was case referred to medical examiner?

1 Yes ≥ No

27 Manner of Death

2 Accident

3 Suicide 4 Homicide

29a. Certifier

21. Signature of Funeral Service Licenses

Due to (or as a consequence of): 9 Unknown

Chronic

Due to (or as a consequence of):

Due to for as a consequence of

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 Other (specify)

Hospital: Inpatient 2 ER/Outpatient 3 DOA

Obstructive

3 Ectopic pregnancy

tulmonary

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

23d. Date of delivery

Month

24a. Was an autopsy 1 □ Yes 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Peaceful Alternatives Funeral & Cremation Ctr. P.A. 2325 York Road Timonium, Maryland 21093

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No

Day

Year

Approximate Interval Between Onset and Death

5 ☐ Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐	□No	28d. Describe how injury occurred				
6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street, facto	ory, office		28f. Location (Street and Number or Rural Route Number City or Town, State)				
	L. Januaring, etc. (opeon				City of Town, State)				
Certifying Physi	cian: To the best of my kno	owledge, death occurr	ed at the time, date	and place,	and due to the cause(s) and manner as stated.				
Medical Examine	er: On the basis of examina	ation and/or investigati	on, in my opinion, de	eath occur	red at the time, date and place, and due to the cause(s)				
	and manner stated.	o o							

29b. Signature and title of certifier
Mana

29c. License number D63054 29d. Date signed (Month, Day, Year) JANUARY 7, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 Franklin Sanne Dave, Baltimore maryland 21237 31. Date filed (Month, Day, Year)

MAJIO E. CINA M.D.

State Registrar

Medical

1 Certifying P

2 Medical Exa



DHMH 17 Rev 1/2001

09-00212 Shirley E. Worcester

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 00334

		- For State Registrar		Cer	tificate of	Death			Reg.	No.		
Physicia edical Examir	n/	1. Decedent's Name (First, Middle, Shirley	E •	Worcest			\ . ·	Mon Jani	of Death	ay Year 009	3. Time of Death 2110 hrs	
7		4a. Facility Name (if not institution, Franklin Square Hospita	-	number)		4b. City, Town, or Rosedale	Location of D	* . '		4c. County of D	County	
Funeral Director		,	Sex	7. Age (In yrs. la		If Under 1 Year Months Days		Min.	te of Birth(I	Fo	Birthplace (State or or or or or or or or or or or or or	
w any	-	Usual Residence of Decedent 10a. State 10b. County			Town or Local						10d. Inside City Limits 1 Yes 2 No	
Aaryland 28a-f show 1 at ouce.	ģ	Maryland Baltim	ore	Midd	lle Riv	er 10f. Zip Code			100	. Citizen of What	21	
h the Mar 3a or 28a	Director	8 Whitethorn Wa				212				USA		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland reart of Health and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Mar			lf \	es Decedent of His Yes, specify Cuban	, Mexican, Pu			14. Race - A White, ei	merican Indian, Black, tc. White	
rs afte ural"	<u>a</u>	Widowed 4 Divor 15. Decedent's Education (Specification)	or Dates:			nt's Usual Occupat		d of work do	ne 1	6b. Kind of Busine		
Baltimore, MD 21215-0036 pernit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	pleted	Elementary/Secondary (0-12)		(1-4 or 5+)	,	ost of working life.	DO NOT use	e retired)		Oil Co	ompany	
d with	Comple	17. Father's Name (First, Middle, L	ast)		<u> </u>		18.Mother's N	Name (First,	Middle, Ma	iden Surname)		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be (John Ray Mitche	11					Ruby	Alio			
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ore, of Her If ite		20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal	from State	crematory or o	ther place)			ĺ			
Page ment of		Donation 5 Other Spe	cify:	Bay		rematory					e, Maryland	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		11. Signature of Funeral Service L	icensee			Name and Address					eral Home PA	
Physician		21a. Part I. Enter the disease, or d	polications that	t caused the death	. Do not enter	the mode of dying,	such as card	lac or respir	atory arres	t, shock, or heart	land 21221 Approximate Interval	
Medical	100	failure. List only one cause of	n each line.	Wounds (2) of							Between Onset and Death	
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760, ficate be ex g physician the burial	Mec	IF FEMALE:	page 100 pag	s, outcome of preg	gnancy					23d. Date of de		
687 certific iding	ian/	23b. Was decedent pregnant in the past 12 months?	1	e birth gnant at time of de		etal death 3	Ectopic p	regnancy		Month	Day Year	
Box 68 e death certif the attending ed for use as	Physician	1 Yes 2 No 9 V Unkr		known	eath 5 c	ther (Specify)						
Sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be death. ector: After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the buri.	by Ph	Part II. Other significant condition	ons contributing	g to death but not r	resulting in the	underlying cause	given in Part				te to the cause of death? Probably 4 Unknown	
ds, equire een sig	eted							2	4a. Was ar		re autopsy findings available	
COF law r has b	Completed	l						-	autopsy	ned? dea	or to completion of cause of ath?	
Re: The iffcate	ပိ	25. Was case referred to medical				26 Place	e of Death (C		Yes 2	NO I	Yes 2 No	
rital sician is cert lirecto	Be	examiner?	Hospital:	Inpatient 2 🗸	ER/Outpatier		1045	Nursing Hom		tesidence 6	Other:	
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sled in by the funeral director, page 2 should t	-	1 ✓ Yes 2 No 27. Manner of Death Natural 5 Pendi	lan (Ms	ate of Injury onth Day, Year) , 2009	28b. Time of 2023 hrs	Injury 28c. Inju	ury at Work? Yes 2 ✔ N	Subj	Describe ho	ow injury occurred		
ivisior or Attenc after death Director:	cati	JFellul	tigation	lace of Injury - At h					ocation (St	reet and Number	or Rural Route Number, City	
	Certification:	deter	not be	fy) Alley	ioine, iaini, su	set, factory, office	building, etc.	0	r Town, Sta			
Hospi 24 hou Funer tely fil		29a. Certifier 1 Certifying Ph	vsician: To the	pest of my knowled	dge, death occ	urred at the time, d	late and place	e, and due to	the cause	(s) and manner as	s stated.	
To the Hos within 24 h To the Fur completely	Medical	one) 2 ✓ Medical Exam	niner:On the bas and manne	is of examination a er stated.	and/or investig			rred at the ti				
F × F 5	ž	29b. Signature and title of certified	//			29c. Licen				-	(Month, Day, Year)	
		When Be	asse 4	MY		0.0	.M.E.			January 8, 2	UU S	
6		30. Nam and address of person Metissa Brassell, MD		ause of death (Iter		Penn Street, I	Baltimore	MD 2120)1			
	tate					/						
Regis		M 20 MAI WM 2 N T JO MA 2 L	Carsu	Registrar's signat	AN ON FUR							

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Joseph A. Walter P^{M} 2009 2:36 6, January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Greater Baltimore Medical Center If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Year) Min 89 218-09-4595 Sept. 29, 1919 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Evertines must be notified at once. 10a State 1 ☐ Yes 2 No Director Baltimore Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 U.S.A. 2609 Matthews Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Instrument Maker and Desinger Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alica Eva Wehr John Walter ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2609 Matthews Drive, Baltimore, Maryland 21234 M. Kathleen Walter - Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 1/10/2009 Parkville, Maryland Right Republic Research Research & Cremetion Services - Parkville 8800 Harford Road, Parkville, Maryland 21234 23a. Parth. Index predisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aspiration Precimonia **Physician** /Medical Due to (or as a consequence of): Examiner MYOCARdial Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending pl IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be rector, page 2 sl autopsy performed 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred After t 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the t 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Danthia Soviales MD 00051347 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CYNTHIA SO (IAND M) 6705 N. CHAILES ST BAITING MD 21284

31. Date filed (Month, Day, Year)

32 Registrar's Signature State JAN n 9 2009 Come Registrar

	1	State of Maryland / Department State of Maryland / Department Certain artment of H rtificate of L	lealth and M D <i>eath</i>	lental Hy	giene Reg. No. 2 (009	00336		
Physician	_	Decedent's Name (First, Middle, Last)			Date of De Month	ath Day	Year	3. Time of Death	
/Medical	×.	CECELIA	WILHELM	Location of Death	JANUAR		2009 nty of Death	12:45 A ^M	
Examiner	ľ	4a. Facility Name (If not institution, give street and number) FOREST HILL HEALTH & REHAB CENTER	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	OREST HIL	LL	HARFORD			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ay, Year)	9. Birth	olace (State or Foreign	
Director		215-24-1682			02/13	/1916		yland	
ow ow	- 1-	10a. State 10b. County 10c. City, Town or Lo	cation				1	10d. Inside City Limits	
a-f sh	2	Maryland Harford Forest H	ill					1 □ Yes 2k No	
vith the		10. Street and Number	10f. Zip Code			10g. Citizen o		ntry?	
iffer death with the Mar ritems 23a or 28a-f sl liner must be notified		110 Gwen Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21050 Was Decedent of H) ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No	U.S.A.	lace - Ameri		
after d	5	1 Never Married 2 Married 1 Yes 2 No	lf Yes, specify Cuba 1 □ Yes 2 ₺ No	an, Mexican, Puerto Specify:	Rican, etc.)	Spec	lack, White,		
ural", o		3 ☑ Widowed 4 □ Divorced Year or Dates:	dent's Usual Occup			16b. Kind of	MII	ite	
in 72 l	200	(Specify only highest grade completed) (Give	kind of work done of NOT use retired	during most of work i)	ing	TOD. KING OF	Dusiness/iii	loustry	
A I A 13-U-O	[Elementary/Secondary (0-12) College (1-4or 5+) 8 Homem	aker			Own H			
be filed within 72 hours after death with the Marylan tal Hygiene. Independent than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Po Completed by Finneral Director	ם ב	17. Father's Name (First, Middle, Last)		18. Mother's Name	•	, Maiden Surn	ame)		
hould d Mer marke	2 -	Harry Trautman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailit	ng Address (Street	Carrie I		ner, City or Tow	vn, State, Zij	o Code)	
2 5 # 2 E			wen Drive	, Forest	Hill,	Marylar	nd 210	50	
es 1 a of Hez		20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State	osition (Name of matory or other place	ce)	Date	20c. Locatio	n - City or T	own, State	
Datumor permit. Pages Department of i Important: If its any Injury or o once.		4 □ Donation 5 □ Other (Specify) Bayview C	rematory,	Inc. 01/09	9/2009	Baltim	ore,	Maryland	
Dai permit Depar Impor any In		21. Signature of Funeral GetVice Licensee	2. Name and Addre Br	ss of Eacility UZďZinski Castern Av	Funer	al Home	P.A	201221	
		23a. Papt. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.					нат ут	Approximate Interval Between	
> Physician	Ì							Onset and Death	
/Medical Examiner		disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):	-						
	5	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	Jolinia						
d ansit	Examiner	Cause (Disease or Injury	o Swere oral dysphagen						
e exection and unial-th	វ័	resulting in death) Last Due to (or as a consequence of):	V . V						
ords, P.O. Box 68/60, requires that the death certificate be executed een signed by the attending physician and and and the detached for use as the burial-transit	200	d							
box be leath certific attending p	rnysician/ine	IF FEMALE: 23b. Was decedent pregnant	75			23d.	Date of deliv	very	
death	SICIA	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5 I	□Ectopic pregnancy □ Other <i>(specify)</i>	y 			Month	Day Year	
w requires that the diben signed by the should be detached	ž l	9 ☐ Unknown Part ii. Other significant conditions contributing to death but not resulting in the u	nderiving cause giv	en in Part I.	23e. Did	tobacco use co	ontribute to	the cause of death?	
dS, uires t signe id be c	ממ	PRE	,		1 🗆	Yes 2 □ No	3 □ Pro	bably 4 Unknown	
	Completed				24a. Was		b. Were aut	opsy findings available	
_ i age	É				auto perf 1∐ Yes	ormed? 2 No	prior to co death? 1 ☐ Yes	ompletion of cause of 2 No	
VITAI HEC sician: The law certificate has t irector, page 2 s		25. Was case referred to medical examiner? Hospital: Hospital:	-t 3CIDOA Oth	26. Place of Deat					
Physical direction	0	27. Manner of Death 28a. Date of Injury 28b. Time of	IL 3 DOA	4 Linursing Ho		how injury occ		ify)	
ION C nding P uth. r: After t e funera	ation	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation		k? Yes 2 □ No					
DIVISION I or Attending after death. I Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office		28f. Location City or To	(Street and Nu wn, State)	mber or Rui	al Route Number,	
		29a, Certifier Certifying Physician: To the best of my knowledge, dear	th occurred at the ti	me date and place	and due to the	cause(s) and	manner as	stated	
To the Hos within 24 hc To the Fun completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.							
To th withir To th comp	ME	29b. Signature and title of certifier	29c. Licens	e number		29d. Date sig	ned (Month	, Day, Year)	
		Dank To		2257		JAN 8	, 20	-9	
V		30. Name and address of person who completed cause of death (Item 23a) (Type, DAVID DUNN - 615 W. MACPHAIL ROAD		IR, MD.	21014				
State	e	24 Date Clad (Marth Day Very)		EK, III.	<u> </u>				
Registra	r	JAN 0 9 2009 Since A. January							

DHMH 17 Rev 1/2001

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** WALKER LAYMOND /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SHOCK TRAUMA UMMS If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Funera! Months Days Hours Min 219-69-7721 Director Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner i just be rightled at Director MD Harford Forest Hill 10e. Street and Number 10f. Zip Code 2912 Kathleen Drive 21050 Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Me any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Home Improvement Specialist 17. Father's Name (First, Middle, Last) John A. Walker ဂ 19a. Informant's Name/Relationship (Type. Print) Mary J. Walker (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory

16b. Kind of Business/Industry Self Employeed 18. Mother's Name (First, Middle, Maiden Surname) Marjorie Margerson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2912 Kathleen Dr Forest Hill, MD 21050 20c. Location - City or Town, State Date 01-07-2009 Baltimore, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir MacPhail Rd Bel Air, MD 21014 Inc. 610 W. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. WITHDRAWAL OF MEDICAL SUPPORT HOURS BRAINSTEM COMPRESSION AND MERNIATION CERTIFICATION APPROVED IN MEDICAL ELIMINES SUBDURAL HIBMATONA 23d. Date of delivery 3 Ectopic pregnancy Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Reg. No.

05-04-1947

09

BATMORE

County of Death

10g. Citizen of What Country?

Race - American Indian, Black, White, etc.

White

England

Specify:

00337

3. Time of Death

6:05 PM

Birthplace (State or Foreign Country)

Grimsby, England

10d. Inside City Limits

1 ☐Yes 2 No

Physician /Medical Examiner

attending physician and

certificate

Director:

within 24 hours a To the Funeral C

Completed by

Be (

Certification: To

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical

Immediate Cause (Final disease or condition resulting in death)

21. Signature of Funeral Service Licensee

Due to (or as a consequence of) WARFARIN

23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 9 Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

Due to (or as a consequence of)

5 Other (specify) 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 Yes 2 ☐ No Hospital 1 npatient 2 ER/Outpatient 3 DOA

Date of Injury (Month, Day, Year) 28b. Time of Injury investigation

0800 AM 15-08 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2

> Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

1 □Yes

24a. Was an

autopsy performed? Yes 2 200

MOON SLIP ON ICE

281. Location (Street and Number or Rural Route Number, City or Town, State) 2912 Kathleen Dr. Forest Hill, M PRIVEWAY MOME

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature as title of certifier

5 Pending

6 Could not be determined

29c. License number NPT 1437130184 29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?

2 XNo

1 ☐ Yes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 Suicide

29a. Certifier

H9320C HIBBR GREENS ST. BAUT, MD

State

32. Registrar's Signature

ORIGINAL

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. P.0. Division of Vital Records,

> Registrar DHMH 17 Rev 1/2001

09

60 21215-0036 Woll YARRIET

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 01 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Fallston 1605 Fallston Rd. If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 💆 🗖 F 218-14-0497 89 Dec.18,1919 **Director** Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exeminer must be notified at 1 ☐Yes 2X No Director White Marsh Maryland Baltimore 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? death with 21162 USA 5601 Ranelagh Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White et 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐Yes 2 No ģ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) איים איים אental Hygiene. רבי ז' איים אental Hygiene. יר traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping-Own Home Housewife 7 yrs. 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental Joseph Bethoulle Elizabeth Grupp ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. 9915 Britinay Lane Baltimore, Md. 21234 Paul S. Wollschlager (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date XX Burial 2 Cremation 3 Removal from State 1-12-2009 Parkwood Cemetery Baltimore, Md. 4 □ Donation 5 □ Other (Specify) ^{22. Name and Address of Facility} Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 21. Signature of Funeral Service Licensee Jassohn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MELLITUS **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 □Yes PINo To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ FO AMBRITIS P No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 ☐ Yes 2 2 25. Was case referred to medical examiner? DAUUHTIER Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Most Christico Ave, Balto, MD 21237 30. Name and address of person yno completed cause of death (Item 23a) (Type, Print) ARWI N 2. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN n 9 2009 Registrar

ougene Olond V		1- For State	ate of Maryland	/ Departn	nent o	Health ar Death		Hygiene		200	9 0033
Physicia	n/	Registrar 1. Decedent's Name (First, Midd	le,Last)					2. Date of De			3. Time of Death
Medical Examir		Lougene a	21 and Willi	Amo,	TIL.			Month January	4, 2009	Year	2302 hrs
		4a. Facility Name (if not instituted Johns Hopkins Bayvie	on, give street and number)			r Location of Dea	ith or	.4c. Co	unty of Death	
Funeral		5. Social Security Number		ge (In yrs. last b	irthdou/	Baltimore If Under 1 Ye	or It Hadas 245	Irs. 8 Date of B	inth (AAAA/DD)	N/A	anloss (State or
Director		215-25-2174		20		Months Da	ys Hours M	lin.	`	Foreigi	1
	- 1	Usual Residence of Decedent	112M 2_F	20	Yrs			007 2	1,1988	5 000	intry) MD
any	ı	10a. State 10b. County		10c. City, Tow	n or Locat	ion		P), I			10d. Inside City Limits
Maryland 28a-f show 1 at once.	ا ة	MD N	A	Ba	1+um	10f. Zip Code	rity				1 Yes 2 No
Maryl 28a-f d at o	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Coun	try?
		4014 Ches	mont Avei	nue		212	06		(1.5.A	
ath wil	Funeral	11. Marital Status 1 Never Married 2 M	12. Was Decedent Armed Forces'				ispanic Origin? (an, Mexican, Puer			Race - Americ White, etc.	an Indian, Black,
ter de:			1 Yes 2	No		Yes 2 L No	o specific	IE '	Sne	cify: Bla	ci
urs af tural'	핡	15. Decedent's Education (Spe	or Dates:	mpleted) 16a			ation (Give kind o	of work done		of Business/Ir	
5 72 ho n "na sal Ex	Completed	Elementary/Secondary (0-12)		5+)		_	e. DO NOT use n				
21215-0036 Juld be filed within 72 Mental Hygiene. marked other than	립	12	_ 0	ŧ	ruce	essor/S	xules ma		- 1	othen	9
15-C		17. Father's Name (First, Middle	. ,			,		me (First, Middle,			
212'	o Be	Lougene 0. 19a. Informant's Name/Relations	Williams,	Jr.	Oh Mailin	Addross (Stee	eet and Number o	tte n	1. Se	vell	7in Onda
nore, MD 21215-0036 sges I and 2 should be filed within 72 hours nt of Health and Mental Hygiene. Fireton 27 is marked other than "natural other transmatic event, the Medical Exami	-	Lynefle M. 20a. Method of Disposition	Sowell mi	other	4010	+ CINEC	mont A	ve Bal	timer	m MD	21206
s l and 2 s of Health ar If item 27	1						emetery,	Date	20c. Loca	tion - City or	Fown, State
Baltimore, permit. Pages I a Department of He Important: If ite ujury or other tr	1	1 Burial 2 Cremation		tate crem	atory or ot	ner place)	1 Ja	n 16.2009	Ball	imore	. mb
Baltimo permit. Page Department Important: injury or otl	T	4 Donation 5 Other S 21. Signature of Funeral Service	Licensee	110121	22.1	lame and Addres	ss of Facility			Dalue	
ii ii Ge ga		Ronald a	Mayson			Rencued 1	al Ja ss of Facility A GNA-	ysan Fu	neral 2	-circle	
Physician		23a. Part I. Enter the disease, or failure. List only one cause	complications that caused on each line.	the death. Do	not enter t	ne mode of dying	g, such as cardiad	or respiratory a	rest, shock,	or heart	Approximate Interval Between Onset and
/Medical xaminer	1	Immediate Cause (Final disease	a. Gunshot Wound		rso						Death
		or condition resulting in death)	Due to (or as a cons	equence of):							
	힐	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	equence of):							
	티	(Disease or injury that initiated	c. Due to (or as a cons	anuanes of):				*			
executed ian and ial - transit		events resulting in death) Last	d.	equence or).							
be executed sician and unial - transit	dical	UNPENDED	AMENDED								-
'60, cate be physici he buri		IF FEMALE:	23c. If yes, outcor	me of pregnand	ry .				23d. Da	te of delivery	
Box 68760 e death certificate b the attending physical for use as the bu	ician/Me	23b. Was decedent pregnant in the past 12 months?	December 1	t time of death	-	tal death 3	Ectopic preg	nancy	Mor	nth D	ay Year
Sox death e atter for u	1	1 Yes 2 No 9 Un		t time of death	5 Ot	her (Specify)					
that the denced by the		Part II. Other significant condit		th but not result	ing in the ι	inderlying cause	given in Part I.	23e. Did	tobacco use	contribute to t	he cause of death?
PO rres that the signed by	g P							1 Ye	es 2 V No	3 Prob	ably 4 Unknown
ords, l	를 ê							24a. Was			opsy findings available ompletion of cause of
eco he law ate has age 2 sl	Completed							perf	ormed?	death?	
Division of Vital Records, rat or Attending Physician: The law requiring a staffer death. al Director: After this certificate has been is deen in by the funeral director, page 2 should have the funeral director.	O	25. Was case referred to medica	il			26.Plac	e of Death (Chec				, <u> </u>
Vita hysici this c	90	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	ent 2 🗸 ER/	Outpatient	3 DOA	Other Nurs	sing Home 5	Residence	6 Other:	
n of Vi		27. Manner of Death 1 Natural 5 Death	28a. Date of Inju (Month Day, Y Jan 4, 2009	ury 28b Year) 22	. Time of I 20 hrs		ury at Work?	28d. Describe Subject she		ccurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
ivisior or Attend after death. Director:	Ĭġ	Pend	stigation				Yes 2 V No	1			
Divis	ertification:		id not be		farm, stree	et, factory, office	building, etc.	or Town.	State)		al Route Number, City
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To the Hos within 24 h To the Fur	ıά	(Check only Certifying P	hysician: To the best of m miner:On the basis of exa								
To Tool	ጅͰ	29b. Signature and title of certifie	and manner stated.				se number	-		signed (Mon	
		10th. () -	DOOL			0.0	.M.E.			y 5, 2009	
	+	30. Name and address of person	who completed cause of c	death (Item 23a))				.1		*****
9		Patricia Aronica-Polla	k MD. Assistant N	Medical Exa	miner	111 Penn S	treet, Baltimo	ore, MD 2120)1		
Sta	te	31. Date filed (Month, Day, Year)	- 32. Registra	ar's Signature	1		•				

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] 9 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner nerce 7. Age (In yrs. Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Hours 215-30-5547 74 **Director** Oct.26,1934 S.Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Funeral Director MD N/A Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 508 S. Madeira Street 21231 USA or Items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Specify: Black 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City than Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens important: if item 27 is marked other the any Injury or other traumatic event, the once. Water Department Construction Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Warsaw Ollie Mae Stevens 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 2 Best Avenue Windsor Mill, MD 21244 Andre D. Warsaw/ 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 1/12/09 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral 4210 Belair Road Baltimore, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** recks /Medical resulting in death) Almanay Discase Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and use as the burial-transi Due to (or as a consequence of): Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) P.O. I יט ווויס דיים החוז או Atter this certificate has been signed by the נ completely filled in by the funeral director, page 2 should be detached i 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 **X**No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 **(2)** lo 1 Tes Certification: To 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 29b. Signature and 29c. License number vho completed car State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b, 29dperDVR, C887, 1/9/09, WS
State of Maryland Department of Health and Mental Hygiene 0 00341 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Year Month 12:45 P.M Rachel Hamill Walter January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda 5919 Walton Road 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 1922 Massachusetts If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday, Days Months Hours 1 ☐ M 2 🔀 F Oct. 11 216-12-4411 86 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 ☐ Yes 2 No Maryland Montgomery Bethesda 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20817 United States 5919 Walton Road 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 ⊠ No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banking Bank Manager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gertrude Reynolds George Keenan Hamill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 801 Linslade Street, Gaithersburg, MD 20878 William H. Brown, Sr./Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 2009 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 13, 2008 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Cemetery 21. Signature of Funeral Service inconsee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M00896 7557 Wisconsin Ave., Bethesda, Maryland 20814 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause reinal disease or condition resulting in death) 1 Coronary Artery Disease year Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary disease 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed' 1 ☐Yes 2 🖾 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1[XYes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

Director

Funeral

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Pages 1

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permit. Page: Department o Important: If any injury or once.

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar in ust be natified at

Examiner and burial-tran physician the as attending use for ned by the a signed I page 2 s has funeral director. After 1

9 Unknown

29a. Certifier

Physician/Medical ≥ Completed Be Certification: To after death.

I Director: Al filled in by

27. Manner of Death 1 X Natural 2 Accident 3 ☐ Suicide 4 Homicide

29b. Signature and title of certifier

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

29c. License number D09577

28f. Location (Street and Number or Rural Route Number, City or Town, State) 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year) January 8, 2008

10400 Connecticut Ave., Suite 606, Kensington, MD 20895 Richard Pollen, M.D., 31. Date filed (Month, Day, Year).

State Registrar

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Medical

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within 24 hor To the Fune completely f

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 00342 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 2009 A M 9:53 Edgar Windham Robert /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours Min. 89 May 23, 237-16-4231 1919 North Carolina Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b County 10c, City, Town or Location ral", or items 23a or 28a-f show Examination of the continuation of 1 X Yes 2 □ No Director Chevy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be filed within 72 hours after death with that Hygiene.
ed other than "natural", or items 23a or sevent, the Medical Examination to a 20815 United States 12 Hesketh Street Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ⊠Yes 2 □ No 1942—
If ¥es, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White Completed by 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Security Storage Elementary/Secondary (0-12) College (1-4or 5+) President Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be s 1 and 2 should be fill flealth and Mental H Item 27 is marked oth other traumatic even Sula Case ဂ္ George W. Windham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R. Craig Windham / Son 10717 Kings Riding Way, #201, Rockville, MD 20852 permit. Pages 1 and Department of Healt: Important: If item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition January 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 8, 2009 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01305 23a. Part 1. The the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediat Tause (Final Physician Bladder Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine nding physician and se as the burial-tran Box 68760, & Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atten for us 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s nas autopsy perform certificate 1 ∐ Yes 2 🔯 No 1 ☐ Yes 2 ☐ No Division of Vital Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 X No 1 ☐ Inpatient 2 🖾 ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 5 Pending investigation 1K Natural 1 ☐ Yes 2 ☐ No neral Director; / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific January 6, 2009 D26259 144 30. Name and address of person who completed cause of wath (Item 23a) (Type, Print) 8218 Wisconsin Avenue, Bethesda, Maryland 20814 Ava Kaufman, M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State parket Registrar

DHMH 17 Rev 1/2001

Nindlam, Robert

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 04 2009 23:31 01 Young Sr. Cornelius William /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Belair Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 XM 2 □ F 04 30 MD Director 65 215-40-8158 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State other than "natural", or Items 23a or 28a-f show vent, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Edgewood Harford MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21040 U.S.A. 1923 Eloise Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🎾 No Specify: Black Specify: Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Baltimore Gas 15. Decedent's Education (Specify only highest grade completed) 12th grade (0-12) College (1-4or 5+) and Electric Co. Meter Leader 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Christie Conway ၉ Robert Young Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michelle Mitchell-Daughter 7733 Bristol Square Court, Springfield, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Manual 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 1/13/09 Owings Mills, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21 Signature of Funeral Service Licensee 21215 Approximate Interval Between Onset and Death 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1/e nociate Cause (Final 051 **Physician** 5 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner onges Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and The law requires that the death certificate be exec Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 menths? Month Day Year 5 Other (specify) 1 Yes No 9 Unknown 4☐Pregnant at time of death Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 Yo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 24a. Was an certificate 1∐ Yes Division or Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) l: Inpatient 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Vatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29b. Signature and title of certifier. 060768

Registrar

Huhammad 31. Date filed (Month, Day;-Year)-

32. Registrar's Signature

30. Name and address of person who completed eause of death (Item 23a) (Type, Print)

Jokhoda

se of death (Item 23a) (Type, Print)
- 500 Uffer Charafeak Dr. Belair

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 200% Arthur Adams, Jr. January Charles 12:17pm^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster Carrol1 8. Date of Birth (Month, Day, Year) Nov. 27, 1 Birthplace (State or Foreign Country)
 TT A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Months Days Hours Min 227-22-4964 82 Director VA 1926 Usual Residence of Decedent death with the Maryland 10a. State 10c. City. Town or Location ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, If a Medical Examinat has be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No MD Howard Elkridge 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6521 Arrow Way 21075 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: WW∏ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or it may Injury or other traumatic event, it a Medical Examin any Injury or other traumatic event, it a Medical Examin any Injury or other traumatic event, it a Medical Examin any Injury or other traumatic event, it a Medical Examin any Injury or other traumatic event, it a Medical Examin 1 ☐ Yes 2 X No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced WWII White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Electrical Lineman Electrical 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Charles A. Adams, Sr. Belva Ruth May ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. June Earlene Adans (Spouse) 6521 Arrow Way Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) All County Cremation 1/10/09 Sykesville, MD 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL. PO Box 195 Sykesville, MD 21784 Her 400764 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day ☐Yes 2☐No 5 ☐ Other (specify) 9 Unknown signed by ner significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 🗌 Yes 2 🗌 No Probably Completed 4 Unknown 1 NFectors 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a, Was an has autonsy certificate perform 1 ☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 \sum Nursing Home Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 5 Residence Other (Spec 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of After 1 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director; 3 Suicide 6 ☐ Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifi

State

Registrar

30. Name and address of pe

31. Date filed (Month

Day, Year)

Maryland 21215-0036

Baltimore,

Records,

Vital

of

Division

DHMH 17 Rev 1/2001

ORIGINAL

on who completed cause of death (Item 23a) (Type, Print)

Pegistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CKRY 7:18A V1/9/11/2 2009 MUZN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westmin TI en VYY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 29, 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Funeral Months Days Hours Min. Country) New York 1 □ M 2 🖾 F 073-18-0564 84 Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturar", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and the notified an once. 1 ☐ Yes 2 🛛 No Director Maryland Carroll New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1624 Old New Windsor Road 21776 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) retail Elementary/Secondary (0-12) College (1-4or 5+) bookkeeping/business accountant/owner-operator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charlotte VonPablo Gifford Burns ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1624 Old New Windsor Rd. Charles H. Acker, Jr./husband New Windsor, MD 21776 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 1/13/2009 Sykesville, MD 22. Name and Address of Facility Hartzler Funeral Home parise (310 Church St. New Windsor, MD 21776 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760. physician at the burial Physician/Medical attending pl IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a P.0. 1 Tyes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 s autopsy performe certificate 2 No 1 □Yes 1 ☐Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the tuneral dir this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 000599443 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) · Asel mo 2955 FURY AR mn(31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN I

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 00346 For State Registrar 1. Decedent's Name (First, Middle, Lest) 2. Date of Death Month **Physician** BEVERLY ALTMAN 7.15 PM JANVAR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 15, 1 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 67 216-38-0704 Director 1941 Maryland Usual Residence of Decedent 10a, State 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits ă Washington Director Clear Spring 1 ☐ Yes 2 ▼ No other traumatic event, the Medical Examiner must be notified 10e. Street and Number 12417 Nesbitt Avenue 10f. Zip-Code 10g. Citizen of What Country? 21722 USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritai Status 1 Yes 2 Notes: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No Specify: white Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 and Mental Hygiene. College (1-4 or 5+) clerk pharmacy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fil.
Department of Heatth and Mental Hy
Important: If Item 27 is marked oth
any Injury or other traumatic event Be Jacob Russell Troupe Inez Pearl Hall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) Bryan T. Altman/son 12417 Nesbitt Avnue Clear Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other) (Specify) 21. Signature of Euneral Sovice Licensee Ronald S. Wade, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street mas Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final **Physician** MYOCARSIAL INFARCTION DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): ed by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>}</u> Records, MYELOGENOUS 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 2 **N**0 24 hours after death. Funeral Director: After this certificate 1 Yes 2 No 1 ☐ Yes Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: 1 Inpatient 2 - ER/Outpatient 3 - DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🔀 Natural 5 Pending investigation 1 Tes 2 🗌 No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 064931 JANUARY 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID COSGROVE 600 North Wolfe St, Baltimore, MD, 21287 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 2 2009 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 4:30 РМ January Margaret Gregory Bowman /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/08/1927 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months 1 □ M 2 🛛 F Days 403-32-8929 Kentucky 81 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Wheaton MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 U.S.A. 12041 Valleywood Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Black ģ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State Government Receptionist d 2 should be filed w th and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hattie Chilton Ernest Gregory ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12041 Valleywood Dr., Wheaton, MD 20902 Health Vikki Brooks/Daughter permit. Pages 1 am Department of Heal Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/12/2009 Anatony Gifts Registry Hanover, Maryland 4X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Septce Lice Anatomy Gifts Registry 7522 Connelley Drive, Ste.P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) End-Stage Renal Disease Years /Medical Due to (or as a consequence of): **Examiner** Weeks Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant law requires that the death in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ Dementia, H/O CVA, PVD, Partial Amputation of 1 Yes 2 No 3 Probably 4 Unknown Completed been Left Foot, Type 2 DM, Blind R. Eye 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed After this certificate funeral director, page 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 Natural ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital within 24 hours a 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Supanich 3009 RSM D 0065405 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Supanich, RSM, MD, 1500 Forest Glen Rd., Silver Spring, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 1 2 2009

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1 - For State Registrar 00348 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2121 Emeric William Bratt /Medical Fasility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** If Under 1 Year 8. Date of Birth (Month, Day, Year 12/9/1936 5. Social Security Number If Under Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 12 M 2 □ F Months Days Hours Min. 213-34-4693 Yrs Director Balt., Maryland Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore ICIYes 2□No Baltimore 10e, Street and Number 10f. Zip Code 10g Citizen of What Country?
Util ted States 1331 Limit Avenue 21239 America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 225 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐Yes 2\No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) accounting manufacturing 17. Father's Name (First, Middle, Last)
Urban B. Bratt 18. Mother's Name (First, Middle, Maiden Surname) Be Catherine Stella Young ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important; If item 27 is any Injury or other trau once. Catherine D. Tupis/ sister 8702 Avondale Road Parkville, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition January 20c. Location - City or Town, State M2 Burial 2 ☐ Cremation 3 ☐ Removal from State Sagred Heart of Jesus Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 6, Dundalk, Maryland 21. Signature of Funer J Service Licensee eaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Acute Myocardial Immediate Cause (Final disease or condition resulting in death) **Physician** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Obesit. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 1 ☐Yes 2 ☑No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

law requires that the death certificate be executed o σ. Records, of Vital To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Division

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

is marked other than

/Medical Examiner

ysician and e burial-transit

phys. attending p

signed by the a I be detached f

has

page

funeral director

Pages 1 and 2 should be 1 nent of Health and Mental

Baltimore, Maryland

State Registrar

31. Date filed (Month, Day, Year)

IAN 1 2 2009

29b. Signature and title of certifier

29a. Certifier

(Check only

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature

parke

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

00058570

Good Sanaritam Hospill Buttane

09-00279 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Nancy Lee Brison 1- For State Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month January 8, 2009 1622 hrs Medical Examiner Nancy Lee Brison 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 36 Right Wing Drive Middle River **Baltimore County** If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs.-last birthday) **Funeral** Months Days Hours 220-30-8481 Nov.21,1932 Country) MD Director M 2 XF 76 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Middle River Yes 2 XNo MD Baltimore or 28a-f show Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 USA 36 Right Wing Drive Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? White, etc. Never Married 2 Yes 2 X No ō 3 X Widowed Give Year White Divorced Yes 2 X No specify: Specify: \$ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than "natur c event, the Medical Exam Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Computer Operator Dept. of Defense 12th nt of Health and Mental Hygiene.

If item 27 is marked other the other the Medi 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Casey Thomas Thelma Sonnor Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 2156 Aumakua St. Pearl City Hawaii 96782 David Sauceda 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State Baltimore, 1 X Burial 2 Cremation 3 crematory or other place) Removal from State Sun Set Memorial 1/14/09 Cumberland MD timent c rtant: 7 or oth Donation 5 Other Specify nature of Funeral Service Lice. 22. Name and Address of Facility 300 Mace Ave. Balto. MD eral Home of Essex 21221 Connelly Funeral Home of Es sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Enter the disease, or complications that ca Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Medical Death Hypertensive cardiovascular disease Immediate Cause (Final disease a. xaminer or condition resulting in death) Physician/Medical Examiner attending physician or use as the burial ò

The law requires that the death certificate be executed Records, P.O. Box 68760, Completed certificate has Division of Vital Be After this Medical Certification: To Director: To the

	bue to (or as a consequence o	,,,					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence o	of):	15.81				
(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	of):					
XUNPENDED		permE, g88	37 1/23/09 T	Γ		<u></u>	
IF FEMALE:	23c. If yes, outcome of preg	nancy			23d. Date of delivery		
23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of de	2 Fetal dea		gnancy	Month Day	Year	
1 Yes 2 V No 9 Unknow	^{/n} 9 Unknown						
Part II. Other significant conditions	contributing to death but not r	esulting in the underly	ving cause given in Part I.		bacco use contribute to the		
				24a. Was a autop: perfor	sy prior to commed? death?	esy findings available apletion of cause of	
25. Was case referred to medical		<u> </u>	26.Place of Death (Che	ck only one)			
examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3		rsing Home 5	Residence 6 🗸 Other: Se	cene	
27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe h	now injury occurred		
1 X Natural 5 Pending 2 Accident Investiga	tion		1 Yes 2 No				
3 Suicide 6 Could no	28e Place of Injury - At h	ome, farm, street, fact	ory, office building, etc.	28f. Location (S or Town, S	(Street and Number or Rural Route Number, City		
4 Homicide determine	ed (Specify)			or rown, s	iale)		
29a. Certifier 1 Certifying Physic	cian: To the best of my knowled	ge, death occurred at	the time, date and place,	and due to the cause	e(s) and manner as stated.		
one) 2 Medical Examine	er: On the basis of examination a and manner stated.	and/or investigation, in	my opinion, death occurre	ed at the time, date a	and place, and due to the c	ause(s)	
29b. Signature and title of certifier	and manner stated.		29c. License number		29d. Date signed (Month,	, Day, Year)	
Carol	Hallan		O.C.M.E.		January 11, 2009		
30 Name and address of person who	completed cause of death (Item	1 23a)					

111 Penn Street, Baltimore, MD 21201

State Registra

Carol Allan, MD 31. Date filed (Mon

Assistant Medical Examiner

amend #23e Please Type or Printin Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No.2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 9, 2009 8:00 Wilbur Moore Bigham January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 48 Chatsworth Avenue Reisterstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days 1 € M 2 □ F Months 89 Dec 15, 1919 Maryland Director 217-07-0854 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 □Yes 2√€ No Director MD Baltimore Reisterstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 48 Chatsworth Avenue U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆ Yes 2 ☐ No If Yes, Give Year or Dates: ₩ ₩ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. ģ Specify: 3 ☑ Widowed 4 ☐ Divorced W W 11 White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Pipefitter Union 536 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Delcie I. John Filmore Bigham Moore ပ permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is marl any Injury or other traumati 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 166 Rockhall, Maryland 21661 Susan D. Becker Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 1/20/09 Garrison Forest Vet Owings Mills, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reisterstown Road hen 5 (2 Reisterstown, MD 21136 Eline Funeral Home Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No 1 □Yes 3 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after dearn.

To the Funeral Director: After this and the funeral director with the funeral director. Certification: To 27. Manner of Teath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ospital or Attending hours after death. 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CP (4ns 60 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Marylar		ficate of D		, ,		9 0035
	Physici	an.	1. Decedent's Name (First, Middle, Las	,				2. Date of Dea	th Day Y	3. Time of Death
	/Medi			ERSON BAXTER,				January	8 200	9 1:15
	Examir	ner	4a. Facility Name (If not institution, give				Location of Death		4c. County of	
	Funeral		ROLAND PARK PLA 5. Social Security Number 6. Se		last birthday)	f Under 1 Year	timore If Under 24 Hrs.	8. Date of Birth	N/	. Birthplace (State or Fore
V	Funeral Director		216-20-7645	XM 2□F 82	Yrs.	fonths Days	Hours Min.	Jan 31	1926	Maryland
	w w		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Locat	ion				10d. Inside City Lim
	Maryla f sho	ŗō	Maryland Baltimor	e County	Balt	imore				1 □Yes 2XI
	r 28a-	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	•
	23a c ust be	ralD	1229 Lake Fal.				210		USA	
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☑ Yes 2 ☐ NowWI If Yes, Give Year or Dates:	T	s Decedent of His es, specify Cubar I Yes 2√ No	spanic Origin? (Sp h, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc.
21215-0036	2 hour atural cal Ex	ted t	15. Decedent's Ed	ucation	16a. Deceden	t's Usual Occupat	tion		16b. Kind of Busi	
215	thin 7. ie. ian "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)			uring most of work		T 0	
121	lled wi Hygier her th nt, the		12 17. Father's Name (<i>First, Middle, Last</i>)	_	Pres	sident	18 Mother's Name		Paper Co	
and	d be f ental F ced ot c evel	To Be	Wiley McPherson	n Baxter Ir					ey Fluhar	
Maryland	shoul and M s marl	۲	19a. Informant's Name/Relationship (7		19b. Mailing A	Address (Street a			r, City or Town, St	
2	12 m		Mrs. Catherine M.							land 21210
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	nemoval mom state	Place of Disposition cemetery, cremate		1 .		20c. Location - Ci	
Itim	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Specify 21. Signature of Fune a Sen/be Licen				ory 1/10			e, Maryland
Ba	Imp onc		Martin D. Lav	accord -	ML'1	ICHELL-W. 00 York	LEDEFELD Road, Ba	FUNERAL ltimore	. HOME, I , Maryla	NC. nd 21212
	- C		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the dea	th. Do not enter t	he mode of dying	, such as cardiac	or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Neh - Hodgik Due to (or as a conse	- 4					Onset and Death
-	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of): [/	,				
	455	Jer	Sequentially list conditions, if any, leading to immediate	b Due to (or as a conse	quence of):					
	cuted nd ransit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C						
60,	tificate be executed ig physician and as the burial-transit	EX	resulting in death) Last	Due to (or as a conse	quence of):					
68760,	icate l physi s the t	dica		d						
Box (eath certif attending for use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregr					23d. Date	of delivery
	ed for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown		ctopic pregnancy ther (specify)			Monti	n Day Year
P.0	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	Phy	9 Unknown Part II. Other significant conditions or		sulting in the unde	rlving cause give	n in Part I	23e Did to	bacco use contrib	ute to the cause of death?
or Vital Records,	uires t signe	d by	,		g	,		1 🗆 Y		☐ Probably 4 ☐ Unknow
COL	sw red s beer s shou	Completed						24a. Was a	n 24b. We	ere autopsy findings availat or to completion of cause o
Re	ysiclan: The lavius certificate has director, page 2	omo						autops perfor 1 Yes	med? de	or to completion of cause o ath?]Yes 2∐ No
/ita	clan: ertifica ector, I	Be C	25. Was case referred to medical examiner?				26. Place of Deat			
Or/	Physic this c	은	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatient 2 2	ER/Outpatient 28b. Time of	3 DOA Other	4 Mursing Ho		ence 6 □Other	
ono	ding Ph h. After thi funeral	tion:	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Injury Work? M 1 TY	es 2 □No	28a. Describe no	ow injury occurred	1
Division	l or Atter after deat Director	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At h building, etc. (Spec	nome, farm, street ify)	, factory, office		28f. Location (Si City or Town	treet and Number n, State)	or Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, it	Medical C		ysician: To the best of my kn niner: On the basis of examin and manner stated.						
	To th withir To th comp	Me	29b. Signature and title of certifier	^		29c. License				Month, Day, Year)
	7		N7. Isabelle VI	ac yelgor	いつ	0/3	657		January	19,2009
,	10		30. Name and address of person who of ISABELLE MAR	completed cause of death (Ite	m 23a) (Type, Pri	nt)	Baltis	ugro Di	d 2121	
4	7	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	, jo weep			2.21	

DHMH 17 Rev 1/2001

State

Registrar

JAN 1 2 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 00352 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Holly Hill Nursing & Rehab. Ctr. Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 3, 6. Sex Birthplace (State or Foreign Country) **Funeral** ^{Year)} 1917 1 M 2 XF Months Days Hours Min. Aug. Director 207-03-7780 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" ~ " any injury or other traumatic events." 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 No Maryland Baltimore Sparks 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14211 Quail Creek Way, Unit 108 21152 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Y No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Specify. Be Completed by Specify: 3 M Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Clothing Store 8 Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Tylisz Martin ပ္ Kaspryzk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 560 San Gorgonio Street San Diego, CA 92106 Dianne Kernan Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-12-2009 Parkwood Cemetery Baltimore Maryland 21. Signatur 22. Name and Address of Facility e Licensee Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 72 hours disease or condition resulting in death) onia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy performe 2 No 1∏Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

If or Attending Physician: The law requires that the death certificate be executed after death.
Introctor: After this certificate has been signed by the attending physician and P.O. Box 68760,< Division of Vital Records, the funeral

filled in by To the Hospital within 24 hours a To the Funeral L

10

State Registrar

Medical Certification: To

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

(Check only one)

31. Date filed (Month

29b. Signature and title of certifier

1 Inpatient

28a. Date of Injury (Month, Day, Year)

2 No

28c. Injury at Work?

1 ☐ Yes

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 09

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Towson MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20

5 Pending investigation

6 ☐ Could not be

Dav. Year)

determined

7402 York Road # 301 \$2. Registrar's Signature

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 055AM Delphine C. Bond 0 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 6,1924 Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 🙀 F 212-20-3817 84 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanting must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 Lest University Pkwy 21210 **USA** Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 ☐ Yes 2√CXNo Specify Specify: 3 ₩ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Bankino 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard E. Colliflower ည Nellie Eberwein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward J. Bond, IV 1012 Adcock Road Lutherville, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Serv. Corp. 1/9/2009 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Maryland 21204 21. Signature of Funeral Septice Lic 1 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** nknown - oronary disease or condition resulting in death) /Medical Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 **M**o 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Ellicoff City, M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

362

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 0 0 9 00354 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JANUARY 200^{Ygan} 11:20 PM PATSY JUNE BARNETT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A HARFORD GARDENS BALTIMORE 8. Date of Birth (Month, Day, Year) NOV 7, 1931 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Months Hours 1 □ M 2√2 F 77 Director 456-44-2263 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantions must be redilled at Director 1 X Yes 2 ☐ No MD N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 4700 HARFORD RD 21214 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No WHITE <u>ک</u> Specify: 3 □XWidowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE ASSISTANT MEDICAL CENTER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NELLIE MARTIN BRUCE HIBBITT 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2139 WILKER AVE BALTIMORE, MD 21234 19a. Informant's Name/Relationship (Type. Print) JOANNE BARNETT-DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ATLANTIC CREMATORY 1/10/09 GELN BURNIE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 21. Sign were of Fun-ral Service Licenses 6415 BELAIR RD BALTIMORE, MD 21206 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (as a con equence of): Examiner MANNOS Sequentially list conditions, if any leading to immediate Examiner if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) the detached 9 I Inknown 9 Unknown þ ped Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Vas 2/ No certificate åZ No 1 □ Yes 1 ☐ Yes director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2√2No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director; A 2 Accident completely filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Date filed (Month, Day, Year)

32. Registrar's Signatury

Certificate of Death

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)-

ORIGINAL

32. Registrar's Signature

1. Decedent's Name (First, Middle, Last)

2. Date of Death

2009

Specify: White

Month

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

3 ☐ Probably

Year

00355 3. Time of Death

12:03 PM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 X Yes 2 □ No

20904

Approximate Interval Between Onset and Death

Minnesota

Physician

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. NO

			For State Registrar	State of Mar			te of Dea			Reg. No. 2009	00356			
	Physician RUBERT CARDWELL Month							2. Date of Dea	Day Year	- 7W2 - M				
	/Medic Examin		4a. Facility Name (If not institution, give	Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death							ath			
ا ا	UNIVERSITY OF MARYLAND BALTIMORE							R Date of Bir	N/A					
	Funeral Director		5. Social Security Number 6. S. 219-62-5491 Usual Residence of Decedent	M 2□F	In yrs. last birth	Months			8. Date of Birt (Month, Da Nov 1	Sirth Day, Year) 9. Birthplace (State or Foreign Country) 17, 1956 Maryland				
	yland how at	Director	10a. State 10b. County		10d. Inside City Limits									
	ne Mai 8a-f s ptified		Maryland Balti	Baltimore					1 M Yes 2 No					
	with the		10e. Street and Number 6829 Fox Meadow Road	I		10f. Z	ip Code 2	1207		10g. Citizen of What C	S.A.			
9	be filed within 72 hours after death with the Maryland Hygiene. d althygiene. d other than "natural", or items 23a or 28a-f show event, Inc. I redice Evaminer must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	er in U.S.	_	edent of Hispanio	pecify Yes or No Rican, etc.)							
003	ural", c	d by	3 ☐ Widowed 4 ☐ Divorced	10. 5	1 □Yes			Specify: Black						
-5	in 72 h n "nat	To Be Completed	15. Decedent's Ed (Specify only highest gra	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b. Kind of Business/Industry					
212	be filed within 72 ho ttal Hygiene. id other than "natur event, the Medical		Elementary/Secondary (0-12)			Longshore			Waterfront					
Maryland 21215-0036			17. Father's Name (First, Middle, Last) 18. Mother's							Name (First, Middle, Maiden Surname) Robertha Mellerson				
ar Ji	SP E E		19a. Informant's Name/Relationship		19b. N	Mailing Addres	ss (Street and Nu	umber or Rui		mber, City or Town, State, Zip Code)				
	tra tra		Morgan Caldwell					Road Ba	ltimore, Ma	ryland 21207				
<u>.</u>	S = = 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Hemovai irom State	20b. Place of E cemetery,	isposition (Na crematory or	ame of other place)		Date	20c. Location - City o				
Baltimore,	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Specify 21. Signatur f Funeral Service Licen		Ar		morial Park and Address of F		01/12/09	Baltimore	e, Maryland			
B	Depi any any		Coall	1.25	101	E	step Brothe	ers Fune	ral Service,	P. A. 1.21217				
4	Physician	¥24	Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CENERAL HOUSE											
	Medicate be executed by the purish transit as the burial-transit a		resulting in death)	consequence of			71/0=	^)	DAVC					
		ē	Sequentially list conditions, if any, leading to immediate	b. Ao ATI	e to (or as a consequence of): OUTIC DISSECTION (TYPE) e to (or as a consequence of):						75			
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C										
60,			resulting in death) Last	Due to (or es a o	consequence of)	:								
68760,	ificate g phys	edical		d						T				
		an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	pregnancy □ Fetal death	al death 3 Ectopic pregnancy				23d. Date of delivery Month Day Year					
P.O. Box	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	Physician/M	1 Yes 2 No	me of death	5 Other (specify)			- Worth Day real					
ري. ح.	w requires that the disbeen signed by the should be detached	by Ph							23e. Did t	23e. Did tobacco use contribute to the cause of death?				
Records,	equire een sig ould b	ted k							1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown					
Sec.	e law n has b ye 2 sh	Completed							24a. Was an autopsy prior to completion of cause of death?					
Vital	sician: The la certificate ha irector, page?		25. Was case referred to medical				26 F	Place of Deat	1 Yes	2 □ No 1 □ Ye				
<u> </u>	To the Hospital or Attending Physician: within L4 hours after death. To the Funeral Director. After this certifical completely filled in by the funeral director, to	To Be	examiner? 1	Other:										
0 u		ion:	27. Manner of Death 1 Natural 5 □ Pending	(Year) Injury Work?			28d. Describe how injury occurred							
Division of		Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	- At home, farn (Specify)	M 1 □Yes 2 □No ne, farm, street, factory, office 28f. Locatic City or			28f. Location (: City or Tox	n (Street and Number or Rural Route Number, Town, State)					
			29a. Certifier (Chack only one) Chack											
	To the vithin To the complex		29b. Signature and title of certifier 29c. License number						29d. Date signed (Month, Day, Year)					
	<		r GEOGE Shenfell Mb D66335							ST BALTIMORE MD				
1	0		30. Name and address of person who	empleted cause of dea	th (Item 23a) (T	ype, Print)	TH GRE	EENE	57	BALTIMOR	E MD			
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's										

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 6:55 PM Physician LEROY, CRAWFORD JANUARY 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WHILL HOPKILL BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** oex 1 M 2 □ F Days Hours Months D5-16-1927 81 245-22-8441 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and if item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, if a Medical Examinar man be notified at ury or other traumatic event, if a Medical Examinar man be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 XYes 2 □ No Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 U.S.A. 1300 Elwood Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 XYes 2 □ No If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 21v No Specify Black Completed by 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Private Musician 12th 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last)unk Be ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4207 Chatham Rd. Baltimore, MD 21207 James Nelson/Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverdale, Md Riverdale Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityRonald Taylor II Funeral HM. 21 Signature of Puneral Service Licensee Land 108 W. North Ave. Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY FAILURE hw. **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner 2 WEEKS ASPIRATION PUBLIMONIA Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner CEREBELLAR CANCER 2 MONTHS certificate be executed METASTATIC and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. the attending physician Physician/Medical the as APPLICABLE HOT IF FEMALE: use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year for 1 in the past 12 months? Month Dav 5 ☐ Other (specify) P.O. signed by the a □Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**o 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 hpatient 2 this funeral 27. Manner of Death 1 Natural 28a Date of Injury 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: P Hospital or Attending P 24 hours after death. Funeral Director: After t After 1 (Month, Day, Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

completely To the within 2.

Registrar

Medical

29b. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1940 EASTERN AVENUE, BALTIMORE EMMANUEL GOROSPE MID 31. Date filed (Month, Day, Year) JAN 1 2 2009

and manner stated.

MEDICAL RESIDENT

DHMH 17 Rev 1/200

29c. License number

RES - 000

29d. Date signed (Month, Day, Year)

JANUARY 5, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-00145 2009 00358 State of Maryland / Department of Health and Mental Hygiene Nicholas William Campofreda Certificate of Death Registrar 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ January 5, 2009 2302 hrs Medical Examiner Campofreda Nicholas William 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore County Owings Mills 102 Allgate Court If Under 1 Year If Under 24Hrs. 8: Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Foreign Months Hours Davs 216-86-6354 Director 06/04/1967 Country) MD 1 **X**M 41 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No **Glyndon** Baltimore MD death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe notified at USA 21071 6 Bowers Lane 23a 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes Yes 2 X No specify: Specify: If Yes, Give Year White 3 Widowed Divorced "natural" 3 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 72 h other than 21215-0036 permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Imporfaut: If item 27 is marked other than Landscaping Landscaper 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Lois Rosinsky Be A. Nicholas Campofreda 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 13537 Leith Court, Chantilly, VA 20151 Judith A. Johnson Step Mother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a, Method of Disposition Baltimore. crematory or other place Burial 2 X Cremation 3 Removal from State 1/8/09 Winfield, MD South Carroll Crem. Donation 5 Other Specify. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road 21136 Eline Funeral Home MD Reisterstown, ans Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or-respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death Narcotic (heroin) and cocaine intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and AMENDED 23a,27,28a-f, per ME G887 1/16/09 TT Physician/Medical X UNPENDED ed by the attending physician detached for use as the burial Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be-23d. Date of delivery IF FEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Year Month Dav Live birth 3 Ectopic pregnancy 2 past 12 months' Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 ✓ No 3 Probably 4 Unknown ⋧ Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? 1 🗸 Yes 2 1 🗸 page 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Residence 6 V Other: Scene Nursing Home 5 Inpatient ER/Outpatient 3 DOA this 1 Yes No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury After 27. Manner of Death Certification: Natural Yes 2 X No 5 death. Pending Director: 1/5/09 the Fd unk 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 102 Allgate Ct. Owings Mills, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc hours after 6 X Could not be Suicide house (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie January 6, 2009 O.C.M.E.

Drivin 17 Rev 1/2001 OCME 2006

State

Registrar

UCIVIE

Laron Locke MD.

31. Date filed (Mon

ame and address of person who co pleted cause of death (Item 23a)

Assistant Medical Examiner

32 Registrar's Signature

Part Both Buch

ORIGINAL

Borne.

111 Penn Street, Baltimore, MD 21201

		For State Registrar		State of	Marylan		rtment of F tificate of L		nental Hyg R	eg. No. 2	009	00359	
Physicia		1. Decedent's Name (First, Middle, Last) Barbara Ann Dudderar								th Day 8 2	.009	3. Time of Death 3:00pm M	
/Medic Examin		4a. Facility Name (If not institution, give street and number) 410 Valley Meadow Circle Apt. T-2 4b. City, Town, or Location of Death Reisterstown								4c. County of Death Baltimore			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. la 1 ☐ M 2 ☐ 6.					If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) Dec 11	rth 9. Birthplace (State or Fore Country)		elace (State or Foreign htry) MD	
Maryland Fe show	tor										0d. Inside City Limits 1 ☐ Yes 2 🛣 No		
th with the 23a or 28a	Funeral Director	10e. Street and Number 410 Valley Meadow Circle Apt. T-2 10f. Zip Code 21136							1	10g. Citizen of What Country? USA			
be filed within 72 hours after death with the Maryland ital Hygiene. So other than "natural", or items 23a or 28a-f show event, the Modical Examinar must be notified at	2	11. Marital Status 1 X Never Marr 3 ☐ Widowed	ried 2 Married	12. Was Decede Armed Force 1Yes 2 If Yes, Give Year or Date	es? MiNo	- 1	Was Decedent of H f Yes, specify Cuba I □Yes 2X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Bi	ace - Americ ack, White, e ify: Whi	etc.	
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exaging.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)						ring		6b. Kind of Business/Industry Maryland Cup			
uld be filed Jental Hyg rked other tic event, I	To Be C	17. Father's Name (First, Middle, Last) Bailey Peyton Dudderar 18. Mother's Name (First, Middle, Main Effic Good								Maiden Surna	iden Surname)		
and 2 shores atth and 1 and 27 is mare trauma		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Norma Jean Ferguson(Sister) 2008C Rudy Serra Drive Sykesville, MD 21784											
Pages 1. ment of He ant: If iten ury or oth		20a. Method of Dis 1 ☐ Burial 2 4 ☐ Donation	position Cremation 3 ☐ 5 ☐ Other (Speci	☐Removal from St	20b. F c A11	Count	sition <i>(Nam</i> e of natory or other plac y Cremati	on 1-10	-09 S	^{20c.} Location Sykesvi	.11e,	MD	
permit. Depart Import any inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784											
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Suddon Counties Dooth Due to (or as a consequence of):											
ifficate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter funderlying Cause (Disease or injury that initiated events resulting in death) Last b. A cute myocau D(a) Infanction Due to (or as a consequence of): C. COUNTY HE Cut DUDGO Due to (or as a consequence of): d.											
certi iding se a	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown								23d. Date of delivery Month Day Year			
The law requires that the death ate has been signed by the atter page 2 should be detached for u	by	200. Did to the significant conditions continuously to death but not resulting in the underlying datase given in art.										ne cause of death? ably 4 \sum Unknown	
The law recate has be page 2 sho	Be Completed	Pro Diabotes Mellitus							24a. Was a autops perforr 1 □ Yes				
sician certifi rector,		25. Was case referred to medical examiner? Hospital: 26. Place of Death (Check only one)											
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	Certification: To	1 Yes 2 No									Y)		
al or Atters after dea al Director	Certifica	3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Homicide 4 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and No. City or Town, State)									nber or Rura	l Route Number,	
the Hospi in 24 hour he Funer pletely fill	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
Vith Vith Con	Σ	29b. Signature and	title of certifier	` `	4		29c. License	number "	2	9d. Date sign	ed (Month,	Day, Year)	
7.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								09			
Sta	te	31. Date filed (Mor	A. W	ANKO	MNN gistrar's Signa	,750	•	street	, REI	STER	STOW	N, MD 211	
Registr	ar		IAN 100	ono A	car o .	The A	an wal						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** 4:00 a John Henry Davis Jan 7, 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Sinai Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 ☐ F Director 251-26-8823 May 15, 1924 So. Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Tx Yes 2 □ No **Funeral Director** Baltimore Marvland N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2619 Cylburn Avenue 21215 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Yes 2 □ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☐ No 1945 Specify. Completed by 3 Widowed 4 Divorced Black 1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Longshoreman other treumatic event, permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other treumatic event, 18. Mother's Name (First, Middle, Maiden Surname) land 17. Father's Name (First, Middle, Last) Be John Davis Sr. Gernevia Davis ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2619 Cylburn Avenue Baltimore, Maryland 21215 Clara Davis timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01/16/09 Owings Mills, Md. Garrison Forest Veterans Cemetery 21. Signature of Funeral Pervice Lice 22. Name and Address of Facility Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217
Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 6 MONTHS HEAD AND NECK CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as 1 IF FEMALE use 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 XYes 2 No 3 Probably 4 Unknown LUNG CANCER 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 : 1☐ Yes 2.7 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 X DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No I hours after death.

-uneral Director: A
ely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hou. • the Funeral Dire. → Iv filled in by 4 Homicide Hospital or 1 🗷 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Course hay MD 00032186 01-09-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CONRAD MAY MO, BALTIMORE VAMC, IO N. GREENE ST., BALTIMORE MD 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State parke Registrar

7

Physician

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 00361 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day DRETTA 01:50 EBAUER 2009 JANUARY 10 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death N/AJOHNS HOPKINS BAYVIEW MEDICALCENTER TIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Month, Days | Hours | Min. | SEPT | 15,1920 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) MARYLAND Months 88 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No BALTIMORE 10f. Zip Code 10g. Citizen of What Country? CONKLING STREET 21224 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1∐Yes 2∐**X**No Specify. Specify: WHITE 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) SECRETARY MARYLAND DRY DOCK 18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH LIGHTNER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2403 BAILEY ROAD, FOREST HILL, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State HOLY REDEEMER CEM: 1/13/09 BALTIMORE, MARYLAND LILLY & ZEILER INC. FUNERAL HOME S. CONKLING STREET, BALTO., MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RESPIRATORY FAILURE 6 HOURS Due to (or as a consequence of): ZWEEKS PNEUMONIA Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 28No 1 □ Yes 2 NO 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 ☐Yes 2 ☐No Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JANUARY 10,2009 RES -000

State Registrar

DHMH 17 Rev 1/2001

4940 EASTERNAVE, BALTIMORE,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DE

MD

es school

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 00362 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month 2009 Year **Physician** 5, Melvin Elgin January 1:30 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Stella Maris Hospice Lutherville If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F 212-09-1975 89 Director Feb 6, 1918 Maryland Usual Residence of Decedent 10a, State 10h County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD 1 ☐ Yes 2√ No Baltimore Baltimore Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 6600 Ridge Road Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify \$ Specify: white 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) plumber HVAC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk Harry Elgin ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun once. Beth Young/granddaughter 1323 Wildwood Beach Road Essex, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in state 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Wirector Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause to lead of injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami burial-trar Due to (or as a consequence of): of Vital Records, P.O. Box 68760 Physician/Medical the the attending photosic that the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 2X No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 10ther (Specify) HOSPICE 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred I or Attending Patter death. Division 5 Pending investigation 1 X Natural 2 ☐ Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifier

(Check only one) X Nurse Practitatomer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Nurse Practitatomer 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JACKIE JONES, CRNP TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 1 2 2009 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 **Physician** 12:15 A M JANUARY 61 Evelyn Irene Faucheux /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CHARLES MEDICAL CENTER LA PLATA CIVISTA If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 □ M 2 🔀 F 06/14/1920 Virginia Director 88 223-12-0156 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it e Model Examine must be notified at once. La Plata 1 ☐ Yes 2 No Director MD Charles 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20646 101 Wesley Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 🙀 No Specify: Specify: White ò 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beautician/Barber 12 <u>Hairdresser</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peral M. Archer James B. Hamilton 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 37134 E. Winston Dr., Mechanicsville, MD 20659 Paul Faucheux/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/09/2009 Hanover, Maryland Anatomy Gifts Registry 4☑Donation 5 ☐Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee (1) 21076 7522 Connelley Dr., Ste.P, Hanover, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) POLEULION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit COPD Due to (or as a consequence of): Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 C Ectopic pregnancy Month Day Year 5 ☐ Other (specify) this certificate has been signed by the a director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainteness of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0062773 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O. BOX 1070 LA PLATA GARRETT AVE. SALEEM MD AHMED 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 2 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 00364 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day **Physician** 09:45 PM Clemmie Tyrone Fennell Hansary 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Min. 1 ⊈M 2 □ F Months Days Hours 6-9-1959 Director 215-72-0489 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, Item Medical Examples in with the modified at once. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County Director MID N/A Baltimore 1X Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21224 6101 Toone Street USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2√ No Specify. Specify: Black 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) llth grade N/A Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis Fennell Ruby Smith ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto, MD 21224 Valerie L. Fennell-Wife 6101 Toone Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 1-14-2009 Arbutus, MD Arbutus Memorial 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee March East F/H Balto, MD 21202 Toward 1101 E. North Avenue Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Conjustive Heart **Physician** Failure years /Medical Due to tras a consequence of): **Examiner** Cardiopenic shock Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Acute renal Jailin Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Year Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 XYes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide 12 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AT 243 8946 4 ,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATAUA NACU HOSPITAL MI MON ME MORIAL BALTIMORE 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State JAN 12 Registrar Barke

DHMH 17 Rev 1/2001

09-00064 Wilbart Gavins Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 00365

art Ouvino		1- For State		•	Certif	ficate of	Death			Reg	j. N o.		
Physicia		Registrar 1. Decedent's Name (First, M	ddle,Last)					. Date of Death Month	Day 2009ear		me of Death 219 hrs		
dical Exami		Wilbart Gav								January 2,	4c. County of		219183
The second second		4a. Facility Name (if not instit					4b. City, Town Cheverly	n, or Location o	of Death		Prince G		
,		Prince Georges Ho			(In yrs. last	hirthday)	If Under 1		er 24Hrs.	8. Date of Birti	n(MM/DD/YYYY)	9. Birthplac	e (State or Foreign
Funeral Director		5. Social Security Number 101-30-5455	6. Sex		70	Yrs	Months	Days Hours	_	07/27/		Country)	Carolina
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v any		10a. State 10b. Cou	•			own or Locat estvi						1 6	Yes 2 No
Maryland 28a-f show d at once.	ō		nce Geo	rges	FOL	est vi.	10f. Zip Co	ode		10	g. Citizen of Wh	at Country?	
Mary 7 28a- ed at	Director	10e. Street and Number									II C A		
ith the Maryland 23a or 28a-f sho notified at once.		5084 Silver		Was Decedent E	ver in IIS	13. W	as Decedent	747 of Hispanic Ori	gin? (Spe	ecify Yes or No		- American l	ndian, Black,
eath with th items 23a ust be notif	Funeral	11. Marital Status 1 Never Married 2		Armed Forces?	X No	lf `	es, specify C	Juban, Mexicar	, Puerto I	Rican, etc.)	White		
er des	F	3 Widowed 4	Divorced If Ye		No No	1	Yes 2 X	No specify	:		Specify:	Black	
urs afi tural	d by	15 Decedent's Education	Specify only his	ghest grade com	pleted)	16a. Decede	nt's Usual Oc	cupation (Give	kind of w	ork done ed)	16b. Kind of Bu	siness/Indus	try
5-0036 led within 72 hours after tygiene. other than "uatural", the Medical Examiner	Completed	Elementary/Secondary (0	-12)	College (1-4 or 5	+)	Glaze		9		1	Funera	1	
036 zithin ene. er tha	E							18 Mothe	r's Name	(First, Middle, I	Maiden Surname		
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than matic event, the Medica	ြိ									McKelvy			
2121 vuld be Mental marke	Be e			Print)		19b. Mailin	ng Address	(Street and Nu	mber or F	ural Route Nur	nber, City or Tov	n, State, Zip	^{Code)} 20747
MD 2 id 2 shou slith and N m 27 is n sunnatic	卢	Joyce Rowe							Cou		4, Fore	stvill	e, MD
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene, Fiten 27 is marked other than "unatural", or items 23a or 28a-f shor r tranunalic event, the Medical Examiner must be notified at once		20a. Method of Disposition				lace of Dispo ematory or o	osition (Name other place)	of cemetery,		Date	20c. Location	- City or Tow	n, State
Baltimore, MD 2 Department of Iteath and N Important: If item 27 is in Important: other traumatic		1 Burial 2 X Cren		Removal from Sta	iie i			Services	01/1	2/2009	Hanove	r, Mar	yland
		4 Donation 5 Oth 21. Signature Funeral Se	rvi g e Licensee	/		22.	Name and A	ddress of Facil	^{ity} Ard	ent Cre			ces, LLC
Balt permit Depart Import	ľ	150	01			7	522 Co	nnelley	7 Dri	ve, Ste	.N, Han	over,	MD 21076 pproximate interval
Physiciar		23a. Part I. Enter the disea failure. List only one of	se, or complicat	tions that caused ine.	the death.	Do not enter	the mode of	dying, such as	cardiac o	r respiratory ar	rest, strock, or the	f	Between Onset and Death
ledica amine		Immediate Cause (Final dis	sease a Mu	Itiple Injuries								_	- Joan
		or condition resulting in de	ath) Due	to (or as a conse	equence of):							
	1	Sequentially list conditions if any, leading to immediate	Due	to (or as a conse	equence of):							
	Evamine	cause. Enter Underlying C (Disease or injury that initial	iteu Dire	e to (or as a conse	nguence of	1		_					
B .	1	events resulting in death)	Last Due	: (0 (0) as a cons	equence of	,.							
760, icate be executed physician and the burial cransit	3	UNPENDED	X A	MENDED Ite	m#2 n e	erDVR.	G887,1	/12/09	WS				
60, sate be	Modical	IF FEMALE:		23c. If yes, outcor		nancy					23d. Date		Vees
687(certifica nding pl	do do		- 11	1 Live birth Pregnant at	time of de			3 Ecto	pic pregn	ancy	Month	Day	Year
Box 687 e death certific the attending	Si i	1 Yes 2 No 9	Links aven L	9 Unknown	t time or de	ath 5	Other (Speci	ıt y)					
, P.O. Box 687 res that the death certification is signed by the attending		past 12 months? 1 Yes 2 No 9 Part II. Other significant			th but not re	esulting in th	e underlying	cause given in	Part I.				cause of death?
P.O.	der	<u>s</u>								1Y			ly 4 Unknown
ords, w require	o alla									24a. Wa aut	s an 24b opsy	prior to com	osy findings available apletion of cause of
Records, The law requir	e z sn	<u> </u>								per 11 ✔ Yes	formed?	death? 1 ✓ Yes	2 No
tal Rection: The certificate			nedical				- 2	26.Place of Dea	ath (Check	only one)			
ital sician is cert	မ္မ ၂	examiner?	Hos	spital: 1 Inpati	ent 2 🗸	ER/Outpati	ent 3 D	OA Other	Nurs	ng Home 5	Residence 6		
of Vitaling Physician: After this certi	tuneral di	27 Manner of Death	lo	28a. Date of Inj	jury Year)	28b. Time	,,	28c. Injury at W		28d. Describ	e how injury occi n struck by m	rred otor vehi	cle
on on carbing ath.	the fur	1 Natural 5	Pending	Jan 2, 2009		1900 hrs		1Yes 2			•		
Division tal or Attendit rs after death.	n by t	Accident 3 Suicide 6	Investigation Could not be	28e. Place of I				, office building	, etc.	and Thomas	Chatal		Route Number, City
Div pital o	filled	Homicide	determined	(Specify) M									, District Heights, M
Division of Vital Records, P.O. F. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the superal Director:			ying Physician	n: To the best of r	my knowled	ige, death or	ccurred at the	time, date and opinion, death	place, ar occurred	id due to the ca at the time, da	te and place, and	due to the	cause(s)
To the To the	compl	<u> </u>	a	ind manner stated	j.	ariaror irroo		c. License num				gned (Month	
		29b. Signature and title o	Certifier	11 11			125	O.C.M.E.			January	3, 2009	
		Ti arall	Jour.	hall,	200	m 23al			_				
7		30. Name and address of Pamela E. South		mpleted cause of Assistant Med			111 Penn	Street, Ba	Itimore,	MD 21201			
J					rar's Signa		that						
	Sta	88 81 4	2 2000	Vansur		135	64.24						

ORIGINAL

DHMH 17 Rev 1/2001

		-	For State Registrar	State of Maryla		artment of H r <i>tificate of L</i>		1ental Hyg 8	iene eg. No. 2009	00367		
			Decedent's Name (First, Middle, Las	t)				2. Date of Deat	h	3. Time of Death		
	Physicia /Medic		Peggy C	Gochenour				Month January	Day Year 7 2009	7:12 P M		
The same	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	-	4c. County of Death			
j			Frederick M	emorial Hosp			ederick		Freder			
	Funeral		Social Security Number 6. Social Security Number	ex 7. Age (ln) □ M 2 🛣 F	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign ntry)		
-	Director		228-44-4097	LIW ZUALF	73 Yrs.			Sept.2	1,1935 Vii	rginia		
	and w	ŀ	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits		
	f sho	5	MD	,	Smiths	oura				1 ☐Yes 2 XNo		
	the N	Director	MD Frederi 10e. Street and Number	.ck	SILLUIS	10f. Zip Code		1	0g. Citizen of What Cou	ntry?		
	3a or	D	14450 Stottlemye	or Rd		21	783		U.S.A.			
	ms 2:	Funeral	11. Marital Status	12. Was Decedent Ever in	n U.S. 13.		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examination and Demotified at anone.	by Fur	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	Armed Forces? 1		if Yes, specify Cuba 1 □Yes 2 🎛 No	Specify:	Hican, etc.)	Black, White, Specify:	white		
ğ	2 hou	fed	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Business/In			
215	hin 7; an "n Medi	Completed	(Specify only highest gra	de completed) College (1-4or 5+)	life.	DO NOT use retired	during most of work d)	ing				
21	d with	No.	12		Но	memaker			Own home			
nd	tal Hy d oth	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden Surname)			
<u>y</u> la	Ment Ment arked atic e	မ	Herbert Rothgel)			Bertie					
Maryland	2 sh and is m raum		19a. Informant's Name/Relationship (3			r, City or Town, State, Zi	,		
	l and Health		Charles B. Gocher						sburg, MD 2			
Baltimore,	Pages nent of Hant: If Ite		20a. Method of Disposition 1 → Burial 2 → Cremation 3 →	Removal from State		sition (Name of matory or other place			_ ′	· =		
計	it. Pa rtmer rtant njury		4 □ Donation 5 □ Other (Specify	7		n Mem。Gr 2. Name and Addre	dns: 1/12		Frederick,			
Ва	permi Depar Impor any Ir		21. Signature of Funeral Service Acen	Mother	- 1	1802 Libe	erty Rd.,	Liberty	Funeral HOme town, MD 2	e 1762		
			23a. Part . Enter the disease, or company shock, or heart failure. List only	olications that caused the cone cause on each line	death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death		
-	Physician		Immediate Cause (Final disease or condition	a acute	mer c	evelul	infra cto	w		_ L Dr		
-	/Medical Examiner		resulting in death)	Due to (or as a con	sequenc f):	1	10	1976.17				
	Examine	_	Sequentially list conditions,	- Caron	ang c	arfere.	derrein			yeur		
	ted isit	ji	E squentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (of as a con	sequence of).	,				J		
	ficate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a con	sequence of):					years		
58760,	e be e			han	1,5,8	Demá				104		
687	ificate g phy-	edical		· · · · · · · · · · · · · · · · · · ·	11/11/11					The same of the sa		
Вох	anding use a	M/n	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre					23d. Date of deliv	ery ery		
O.	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burlal-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown		☐ Ectopic pregnanc ☐ Other <i>(specify)</i> _	У		Month	Day Year		
<u>P</u>	at the	Phy	9 Unknown				an in Dant I	230 Did to	bacco use contribute to	the cause of death?		
	res tha signed be det	by	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	ndenying cause giv	en in Part I.			bably 4 Unknown		
orc	v requii been s shoufd	Completed	- Empley line	. 0				1	I			
ĕc	elaw hasb je2sh	ם	Chroning	end in	Veffe W	ry,		24a. Was a autops	sy prior to co	opsy findings available ompletion of cause of		
품	ate ⊐	ပ္ပ	aldemul	remotive	with	STEPL	injut	U 1 □Yes	2,⊠No 1 □ Yes	2 🗆 No		
of Vital Records,	ding Physician: The h. h. After this certificate h funeral director, page	B	25. Was case referred to medical examiner?	Hospital:		V Oth	26. Place of Deat		•			
o o	Phys r this ral di	F.	1 Yes 2 Alo 27. Manner of Death	28a. Date of Injury	2 ER/Outpatie	nt 311DOA	4 LI Nursing Ho		ence 6 Other (Speciow injury occurred	ity)		
on	ding I h. After funer	ţi	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Yea	ar) Injury		kí? Yes 2□No					
Division	or Attending Physician: after death. Director: After this certific in by the funeral director.	ilica	3 Suicide 6 Could not be	28e. Place of Injury		reet, factory, office			treet and Number or Rui	ral Route Number,		
ă	al or s afte ii Dire	Certification: To	4 ☐ Homicide determined	building, etc. (Sp	becny)			City or Town	n, State)			
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (nysician: To the best of my niner: On the basis of examination and manner stated.								
	To the within To the	Me	29b. Signature and title of certifier	1		29c. Licens	se number	2	29d. Date signed (Month	Day, Year)		
	-		XA 1/4	dunia		()	22101		Dal A (11 - 7	2009		
	/ Y		30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print)		^	al a	21267		
	4		Hegd HA	Lusan w	147	5 teins	y and	ful	Del Med	21762		
	Sta Registr		31. Date filed (Month, Day, Year) JAN 12 2	32. Registrar's S	signature,	askal	(F				

			Please	Type or Pri							-	
		For State Registrar		State of M	aryland	•	artment of H rtificate of		nd Mental H	- 0	0000	00000
			ne (First, Middle, La	st)			uncate of	Dealli	2. Date of	Reg. N	·2003	3. Time of Death
Physicia		WIL	-LIE	AH	ALL				J Month		ay Year	
/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)	,		4b. City, Town, o	r Location of [4	c. County of Death	
<i>)</i>		UNIVERS		MARTLAND			BAL	Timo			BALTIMO	
Funeral		5. Social Security N	1	Sex 7. Ag	je (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours		Birth Day, Yea	r) Cou	place (State or Foreign ntry)
Director	-	248-66-9 Usual Residence of			68			L .	Dec 1	2, 194	So.	Carolina
rylane show	_	10a. State	10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
Ba-f s	Director	Maryland	N	/A				ltimore		1		Y⊆Yes 2 No
with the	١	10e. Street and Nu 833 West F					10f. Zip Code	04004		10g. C	Citizen of What Cou	
72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Everniner must be notified at	Funeral	11. Marital Status	rati Street	12. Was Decedent	Ever in U.S.	13.	Was Decedent of F	21201 Iispanic Origir	n? (Specify Yes or Puerto Rican, etc.)	No-	U.S.A 14. Race - Ameri	
or ite		1 Never Mar	ried 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give	No		if Y <i>e</i> s, specify Cub 1 □ Yes 2√□ No	an, Mexican, F Specify:	Puerto Rican, etc.)		Black, White,	etc.
ural",	b b	3 ₩ Widowed		Year or Dates:			^			1		lack
n 72 h	Completed		15. Decedent's Educify only highest gra	ade completed)		(Give	dent's Usual Occu _l kind of work done DO NOT use retire	during most o	f working	16b.	Kind of Business/Ir	ndustry
filed within Hygiene. other than ent, the file	E	Elementary/Seco	ondary (0-12)	College (1-4or	5+)			Layer		(Construction	Company
al Hyg	Be C		(First, Middle, Last)				18. Mother's	Name (First, Midd	lle, Maide	en Surname)	
should be and Mental s marked o	ဂ္			nown						Unkn		
12 sh thand 7 is m traum			lame/Relationship (Type. Print)							or Town, State, Zi	p Code)
1 and Health Iem 27 other tu	-	Ruby Robin 20a. Method of Dis			20b. Pla		3 West Pratt sition (Name of matory or other pla		timore, Maryl		Location - City or T	own, State
Pages Tent of Int: If it		tx☐ Burial 2		Removal from State	cen				01/12/09		Lansdowne, I	
: +: € 5 = }			uneral Service Lice	1			Zion Cemete: 2. Name and Addre		01/12/09		Lansuowne, i	viaiyiaiiu
permi Depa Impo any ir once		1	Ma	plications that cause	Ty	37 _	Estep Br	others Fu	neral Service	P. A.	17	_
		snock, or ne	art failure. List only	plications that cause one cause on each li	d the death. ne.	Do not ent	ter the mode of dyi	ng, such as ca	ardiac or respirator	y arrest,	17	Approximate Interval Between
Physician		Immediate Cause disease or conditi- resulting in death)	on	_a	TOCI	ARD	IAZ I	NFAR	CTION			Onset and Death Hours
/Medical Examiner		resulting in death)	•	Due to (or as			15 1					
	er	Sequentially list co if any, leading to in cause. Enter Und Cause (Disease o	onditions, mmediate	b. Due to (or as			1510N					
executed n and ial-transit	Examiner	cause. Enter Und Cause (Disease of that initiated event	erlying r injury ts	C.								
e executed sian and urial-transit	- 1	resulting in death)	Last	Due to (or as	a conseque	ence of):						
eath certificate be ey attending physician for use as the burial	Physician/Medica		•	d							-	
certif nding use as	n/Me	IF FEMALE: 23b. Was deceder	nt pregnant	23c. If yes, outcome	of pregnance	су					23d. Date of deliv	verv
death le atte	icia	in the past 12	2 months?	1 Live birth			☐ Ectopic pr <i>e</i> gnand ☐ Other <i>(specify)</i> _	су		_	Month	Day Year
at the	hys	9 Unknown		g ∐ Unknown								
w requires that the de s been signed by the should be detached	<u>ک</u>	Part II. Other signi		contributing to death t		3	, , ,	en in Part I.				the cause of death?
been	eted	000		NUNDBEFO			rirus				2 No 3 Pro	
ne law e has ge 2 s	ompleted	ADRET		NSUFFI	CIEN	JC-T			— 24a. W	as an itopsy erform a d3	prior to c	opsy findings available ompletion of cause of
an: The tifficate or, pa	ပိ	25. Was case refe		*ism				26 Place o	1 □ Ye	s 220	lo 1 ☐ Yes	2.00 No
ysicia is cer direct	To B	examiner? 1 ☐ Yes 2	2	Hospital: 1 ☐ Inpati	ent 2 E	R/Outpatier	nt 3 DOA Oth	or:			6 ☐ Other (Spec	ifv)
ng Ph fter th		27. Manner of Dea	ath 5 Pending	28a. Date of Inj (Month, Da	ury ay, Year)	8b. Time o	f 28c. Inju				ury occurred	,
tendli leath. Ior: A the fu	catic	2 ☐ Acoident 3 ☐ Suicide	investigatio				M 1 🗆	lYes 2 □ No				
or At after d Direct in by	Certification:	4 Homicide	determined	28e. Place of In	iury - At hom tc. <i>(Specity)</i>	ne, farm, str	eet, factory, office		28f. Location	n (Street a Town, Sta	and Number or Rui ate)	ral Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the I		29a. Certifier (Check only	1 Certifying P 2 Medical Exa	hysician: To the best miner: On the basis	of examination	ledge, deat	th occurred at the to	ime, date and opinion, death	place, and due to	the cause	(s) and manner as	stated. to the cause(s)
thin 2 thin 2 the	Medical	one) 29b. Signature and	d title of certifier	and manner s	tated.		29c, Licens	se number		29d. [Date signed (Month	Day Year)
F 3 F 8) /,	my la	Arath.	2 m		75	054	4	0	1 100 pm	12009
1. 8		30. Name and add	dress of person who	completed cause of	death (Item 2	23a) (Type,	Print)	J) (100	~1004-9	11 2001
U		AMAL MI	ATTU, MD	UNIV. C	F MA	RYLA	ND EME	RGEN	er Dep.	ARTO	NENT	
Sta Registr		31. Date filed (Mo	nth, Day, Year)	32. Regist	rar's Signatu	ire	ND EME					
HMH 17 Rev 1/20		-	JAN 1 2 ZL	119 LANGER	Ad for	1. 180	EAST OF					

DHMH 17 Rev 1/2001

			For State of Maryland		tificate of De		Retail Dygi	g. No. 2009	00369
	Physicia	an	1. Decedent's Name (First, Middle, Last) Janet Louise Heiser				January	Day 2009	7:30 A M
	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo	cation of Death	our.uar ₁	4c. County of Death	7,000 22
	CXAIIIII	eı	Carroll Hospice Dove House		West	minster		Carrol	.1
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🖾 F 7. Age (In yrs. las	t birthday) Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 5,	Year) 1925 Mary	ace (State or Foreign try) Land
pue	w ti		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo	cation			10	Od. Inside City Limits
Mar	a-fsh	ctor	Maryland Carroll		Keymar				1 □Yes 2 No
ith the	or 28	Director	10e. Street and Number		10f. Zip Code	21757	10	g. Citizen of What Coun U.S.A	•
Q Z IZ I 3-0030 Gled within 72 hours after death with the Maryland	tal Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be ruttlied at	Funeral	6219 Middleburg Rd. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of Hispa f Yes, specify Cuban, I		ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, 6	an Indian,
0000	ral", or it	þ	1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:	1	1∐Yes 2⊠ No 8	Specify:			White
ם-ה אַרְּיִּ	"natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give	dent's Usual Occupation kind of work done duri OO NOT use retired)	on ing most of worki	ng 1	6b. Kind of Business/Inc	lustry
7	h and Mental Hygiene. Is marked other than "Iraumatic event, Ire Med	dwo	Elementary/Secondary (0-12) College (1-4or 5+)	mc. I	seamstre			sewing fact	ory
ם פון פל	al Hyg l other	Be C	17. Father's Name (First, Middle, Last)		18		(First, Middle, M		
yian gildh	Ment Marked Marked	2	Franklin Edgar Miller				gie Humb		Code
Mar			19a. Informant's Name/Relationship (Type. Print) Charles R. Heiser/ husband		ng Address (Street and Middlebur			City or Town, State, Zip MD 21757	Code)
re, r	of other traumatic		20a. Method of Disposition 20b. Plac		sition (Name of natory or other place)	-		Oc. Location - City or To	wn, State
Saitimor	ment of I		11 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Met	hodis	t Cemetery			Middleburg,	MD
Dall	permit: rages range bear permit of Heal Important: If item 2 any injury or other once.		21. Signature Denreal Service Licensee		2. Name and Address of E. Broad			neral Home Ige, MD 2179	91
É	hysician /Medical ixaminer	ner	23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a conseque) Sequentially list conditions, if any, leading to minimulate cause. Enter Underlying	nce of):			W M		Approximate Interval Between Onset and Death
5875U,	g physician and as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c	nce of):					
O. BOX	the attending poor	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea	leath 3 [☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of delive Month	ery Day Year
ords, P.O	been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not result	ing in the u	nderlying cause given	in Part I.		acco use contribute to the	
I Hec	ate has	Completed						y prior to co death? 1 ☑ No 1 ☑ Yes	psy findings available mpletion of cause of
	certif	B	25. Was case referred to medical examiner? Hospital: Hospital:	D/O	Othor		h (Check only one		hognigo
on of	ning ringsician, n. After this certific funeral director,	ion: To	27. Manner of Death 1 Matural 5 Pending (Month, Day, Year)	28b. Time o Injury	f 28c. Injury a	4 LI Nursing Ho	28d. Describe ho	nce 6 X Other (Special w injury occurred	y) Nospice
Division	to the prospinal or Autonomy Prinsacion, within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, I	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str			28f. Location (Sti City or Town	reet and Number or Rura , State)	al Route Number,
1	within 24 hours To the Funeral completely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know and manner stated.	ledge, deat on and/or ir	th occurred at the time nvestigation, in my opin	, date and place, nion, death occur	and due to the cared at the time, da	ause(s) and manner as a ate and place, and due to	stated. the cause(s)
1	within To th comp	Me	29b. Signature and title of certifier		29c. License r	number 29 K	25	9d. Date signed (Month,	Day, Year)
•	T		30. Name and address of person who completed cause of death (Item 2	23a) (Type.	Print)	710		-1-12	
,	8		Flavio Kruter mid SSS South	Cente	6 Street (NOSTHIR	SIG IM	DZIIST	
	Sta Regist		31. Date filed (Month, Day, Year) 32. Aegistrar's Signatu	ire	an Mad				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Jan.8,2009 Anthony Hendricks 11:10A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Year) Months Hours Days 1 □ M 2 □ F 54 217 60 4663 17,1954 MD Feb. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits n/a Baltimore 1 Yes 2 □ No 10e. Street and Number 921 N. Patterson Park 10f. Zip Code 10g. Citizen of What Country? 21213 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian. Black, White, etc. 1 M Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: black 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Dietician Johns Hopkins Hosp. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leroy Hendrick Queen Mayo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfreda Spruill (sister) 921 N. Patterson Pk. 21213 Balto,Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 popation 5 Other (Specify) Jan.15,2009 Carmel Cem. Balto, Md. 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home Soprature of Funeral Service Licensee 1412 E. Preston St. Balto, Md.
Do not enter the mode of dying, such as cardiac or respiratory arrest, 21213 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Mon disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to limine late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 🗌 Yes 2 🗌 No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

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28a-f show

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"natural"

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than

72 hours after

Baltimore, Maryland 21215-0036

other traumatic event, the Medical Examiner must be notified at

Examine the death certificate be executed and -trar physician ar the burial-t Physician/Medical

attending p been signed by the should be detached certificate

Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificately filled in by the funeral director, p e Funeral

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Completed

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Certification: To

Medical

State Registrar

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23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

IF FEMALE:

24a. Was an autopsy 1 □Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

25. Was case referred to medical examiner? 1∐Yes 2 No 27. Manner of Death 1 Natural
2 Accident

5 Pending investigation

6 ☐ Could not be

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Mother (Specify) NOSPICE 28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

3 Suicide

4 Homicide

1 🛎 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatu d title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.O

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5. Hanover Sh

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day,

Year)

3001 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 4, **JANUARY** 2009 7:58 Υ. MARVA JENNINGS /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1□M 2🕅 F Yrs JUNE 24, 1936 DC Director 577**-**52-3631 Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7.1s marked other than "natural", or items 23a or 28a-f show traumatic event, 11st Parkeal Evanifier in ust be indiffed at 1 K Yes 2 □ No Director PRINCE GEORGE'S TEMPLE HILLS 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7206 WESTCHESTER DR 20748 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married P Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>6</u> 3 ☑ Widowed 4 ☐ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 12TH HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill Health and Mental H tem 27 Is marked oth Be JOHN E. CARTER ANNIE L. LEWIS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau LAJUANA JENNINGS-TAYLOR/DAUGHTER 12508 MORANO DR BRANDYWINE, MD 20613 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) HARMONY MEMORIAL PARK 01-12-2009 LANDOVER, MD 21. Signature of Foneya Service Licensee 22. Name and Address of Facility MARSHALL S FUNERAL HOME OF MD SUITLAND, MD 20746 DONALD R. GRAY 4308 SUITLAND ROAD complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Oaset and Death 23a. Parr L Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death) ARTERIO **Physician** /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed and Due to (or as a consequence of): burial-Box 687605 physician Physician/Medical the attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ■ No Month Day Year 5 ☐ Other (specify) P.O. the 9 HInknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 2 XNo 3 Probably 4 Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate 1 □Yes Division of Vital Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 KER/Outpatient 3 □ DOA မ this After thi 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident by the i 24 hours after death Funeral Director. 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide cal 29a, Certifier 1🗮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar m 23a) (Type, Print)

Registrar's Signature

address of person who completed cause of death (Ite

iled (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** ISABELL JOHNSON 2009 Avilen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2115 IVERSON STREET TEMPLE HILLS PRINCE GEORGE'S 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours 1 □ M 2 🛛 F 409-36-7703 1912 MS Director 96 27, JULY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show the Middeal Examiner must be notified at Director MD PRINCE GEORGE'S TEMPLE HILLS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö items 23a 2115 IVERSON STREET USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No If Yes, Give Year or Dates: 2 Specify: Specify: 3 X Widowed 4 □ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Maonce. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER PRIVATE 9TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental ဥ DANIEL J. SMOOT ANGELA SMITH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VERLINE LYNN / DAUGHTER 2504 AFTON STREET TEMPLE HILLS, MD 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State CEDAR HILL CEMETERY 01-10-2009 SUITLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD of Tuneral Service Licensee 4308 SUITLAND ROAD DONALD R. GRAY SUITLAND, MD 23a. Part f. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician

/Medical Examiner

> Examiner sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Physician/Medical þ Completed **Director:** After this certific I in by the funeral director, Be Certification: To

The law requires that the death certificate be executed

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Records,

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I or Attending Fafter death. Division

To the Hospital within 24 hours a To the Funeral E

Approximate Interval Between Onset and Death AZ disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 🔲 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 □Yes 2. - No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated

29c. License number

10d. Inside City Limits

20748

29d. Date signed (Month, Day, Year)

1 X Yes 2 ☐ No

Registrar

filled in by

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VS.

3001

Registrar DHMH 17 Rev 1/2001

State

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Registrar's Signature

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P.O. Box 68760, of Vital Records, Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1 9 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 8, 2009 ALPHONSE RONALD LEONE 4:40A 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death None Johns Hopkins Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 10, 1946 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign New York Months Days Hours 1√XM 2□ F 152-34-7422 62 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 1 □Yes 2 □ No New Jersey Huntingdon Annandale 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 08801 5 White Tail Way USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXVIO 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married XX Married 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 ☐ Yes XXNo White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Vice President Engineering 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Domonic Leone Theresa Marie Pellettiere 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patricia Ann Leone Wife 5 White Tail Way Annandale New Jersey 08801 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 □Removal from State Immaculate Conception Jan 13, 2009 Clinton, New Jersey Donation 5 Other (Specify) 22. Name and Address of Factivitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. Part1. Enter the disease or complice shock, or heart failure. List only on Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmanary Embolus Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter trinderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably XXUnknown 1 🔲 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes XX No 24a. Was an performed? 1∐ Yes XX No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: XX Inpatient 1 ☐ Yes XXNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

items 23a death

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner once.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760.

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27. Manner of Death Certific

29a. Certifier Medical 29b. Signature and title of certifier

2 Accident

3 Suicide

4 Homicide

6 ☐ Could not be determined

5 Pending investigation

28a. Date of Injury (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

MD MPH

28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) KertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

29c. License number Res 000

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) January 8, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zoe Ovecki MD MPH 600 North Wolfe Street Baltimore, Maryland 21287

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death **Physician** ap emor 09 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Inputient Hospice
Sex 7. Age (In yrs. last birthday)
1 M 2 DF 8 0 Yrs. ane If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 1□ M 2 F Days Min -30-864 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location ortant; if item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Evanther must be notified at Baltimore 10f. zip Code 1 Nes 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital_Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Johns Hopkins Elementary/Secondary (0-12) College (1-4or 5+) Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 to. Mc Department of Heal Important: If item 2 any injury or other once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, Date **JANUARY** 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 D Cremation 3 ☐ Removal from State T (Rematicw 1/10/09 Hanover md 22. Name and Address of Facility Phillip A. Weatherfired Funeral Services 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Baltimore, MD. 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician PNEUMONIA** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by JESSIE LEMON 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? res 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) **HOSPICE** 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1X Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) X Nurse Practitatone rer stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, \$2. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieneo O O

			For State Registrar	Otato or mary	C	Pertifica	te of De	ath		Reg. No.	2009	003	3/6
	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of De	eath Day	Year	3. Time of	Death
	/Medic				t C. Le				Januar	44	200		M
	Examin	er	4a. Facility Name (If not institution, give s	C 1		10.	1.	cation of Death		4c.	County of Dea		
-	Funeral		5. Social Security Number 6. Sex	17. Age (Ir	n yrs. last birtho			Under 24 Hrs.	8. Date of Bir	th		tholace (State o	r Foreian
	Funeral Director			M 2□F	75 Yr	Months	Days H	lours Min.	(Month, Da	y, Year) 3, 193 3		thplace (State o ountry) Maryland	
	yland iow		10a. State 10b. County	10	c. City, Town o	r Location						10d. Inside Cit	ty Limits
	a-f sh	ctor	Maryland Baltim	ore			Baltin	nore				1 X Yes	2 🗆 No
	s 1 end 2 should be filed within 72 hours efter death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 700 Eastshire Drive			10f. Z	ip Code	21228		10g. Citiz	zen of What Co U.S		
	ems 2	ner	11. Manital Status	12. Was Decedent Ever Armed Forces?	r in U.S.	13. Was Dec	edent of Hispa	inic Origin? (Sp	pecify Yes or No Rican, etc.))- 1	14. Race - Ame Black, Whi		
21215-0036	ral", or its Examine	by	1 ☐ Never Married 2☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		1 ☐ Yes		pecify:	riioan, oto.)		Specity:	Black	
5-0	72 hc	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. D	ecedent's Us Give kind of w	ual Occupation	n ng most of worl	king	16b. Kir	nd of Business	/Industry	
121	vithin he. han "	g Id	Elementary/Secondary (0-12)	College (1-4or 5+)	1//	fe. DO NOT			3	С	ondomini	ım Comple	X
2	Hygie Hygie ther t		17. Father's Name (First, Middle, Last)				Lead Eng		ne (First, Middle	Maidon	Surnamo)		
Maryland	2 should be filed withi and Mental Hygiene. Is marked other than aumatic event, the M	o Be	Albert	Bull			10.	nea Ra	,				
Σ	shoul nd Me mark math	2	19a. Informant's Name/Relationship (Ty)		19b. N	lailing Addres	ss (Street and	Number or Ru	ral Route Numb	er. City or	Town, State.	Zip Code)	
	1 end 2 Health ar em 27 Is ther trau		Odessa Lee			700 Eas							
ore,	ges 1 el it of Hea if Item or othe		20a. Method of Disposition	2	20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Tow								
Ë	Pages nent of f ant: If ite ury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Maryland National Park Cemetery 01/09/09 Laurel, Maryland								
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service License	W. 5	f Facility hers Fune	ral Service,	P. A.	-					
	1 3		23a Part1 Enter the disease, or complishock, or heart failure. List only or	cations that caused the	death Do not	enter the mo	300 Eutav de of dying, s	w Place Ba uch as cardiac	or respiratory a	12121 rrest,		Approximate Interval Bet	9
	Physician		Immediate Cause (Final disease or condition		c . O	rteru	Die	sure				Onset and E	Death
A	/Medical		resulting in death)	Due to (or as a co	-		all	Luxe				years	
н	Examiner		Sequentially list conditions.										
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of)								
	wecut end al-tran	хал	that initiated events resulting in death) Last		onsequence of)	:							
68760,	icate be executed physician end s the burial-transit			,	,								
189	tificate ig physas the	Medical											
.O. Box	The law requires that the death certificate be executed te has been signed by the attending physician end tage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	3 ☐Ectopic 5 ☐ Other (2	3d. Date of de Month	•	/ear
<u>α</u>	that led by detail		Part II. Other significant conditions cor	ntributing to death but no	ot resulting in th	ne underlying	cause given ir	n Part I.	23e. Did 1	obacco us	se contribute t	o the cause of d	eath?
or Vital Records,	quires n sign	d by	Congestive hea	st faile	re	Hup	citers	101	1 🗆	Yes 2	No 3□P	robably 4 □L	Jnknown
00	s been s should	Completed	high Cholesto	181	•	1,			24a. Was	an	24b. Were a	utopsy findings a	available
R	The lav	E O	J						auto perfo 1□ Yes	rmed?	prior to death?	completion of ca	ause of
ita	siclan: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				26	. Place of Deat	th (Check only of		I Tes	2 □ No	
<u>-</u>	hysic this ce	70 E	1 Yes 2 No	lospital: 1 Inpatient	2 ER/Outpa	atient 3 🗆 🗅	Other:	4 Nursing H	ome 5 Resi	dence 6	3 □Other (Spe	ecify)	
n o	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	28b. Tin inju		28c. Injury at Work?		28d. Describe	how injury	y occurred	<u>_</u>	
Sio	tendl leath. tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be			М		2 No					
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	4 Homicide determined	28e_ Place of injury - building, etc. (S	At home, farm Specify)	, street, facto	ry, office		28f. Location (City or To	Street and wn, State)	d Number or R	ural Route Num	ber,
	n 24 hou n 24 hou ne Funer	Medical	29a. Certifier (Check only one) 1 Certifying Physical Certifying Physical Examination (Check only one)	sician: To the best of m ner: On the basis of exa and manner stated	amination and/	leath occurre or investigation	d at the time, on, in my opinion	date and place on, death occu	, and due to the rred at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
	To the Comp	ğ	29b. Signature and life of certifier			2	9c. License nu	mber		29d. Date	e signed (Mon	th, Day, Year)	
	~		Ama T	me who			D005	9914		Tunco	vy 5	-, 200	9
)	0		30. Name and address of person who co	moreted cause of death	(Item 23a) (Ty	pe, Print)	2.0				0		
- 1	U		31. Date filed (Month, Day, Year)	32. Registrar's		ing	RD.	Ball	howe, i	10	21228		
	Sta	ite	I A A 1 1 0 00	00 Se negistrar's	olynature	bearks							

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Certificate of Death

Reg. No. 2009 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2009 al 153 **Physician** James Lorel PM anuary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b, City, Town, or Location of Death **Examiner** Kaltimore General If Under 1 Year | If Under 24 Hre 8. Date of Birth (Month, Day, Aug. 20 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** South Carolina 78 250-52-6437 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyghene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 Nes 2 No Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 10 Specify: Black 2 No Specify ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cab Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown unknown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore David Hawey 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Tan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician umania disease or condition resulting in death) /Medical Dut to (or as a consequence of): Examiner S. cu mally list confliction if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed for use as the burial-tran attending physician and Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 s performed' certificate 1∐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1; Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 1 Natural 2 ☐ Accident Within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) tagras Maryland General Hespr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar NN378 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 Teresa Wanda Lanocha January 8:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore 3208 Rosekemp Ave. 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr. 20,1930 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 □ M 2 ☑ F 218-26-2783 78 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical East invariant to notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 ☐ No Baltimore Glen Arm 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21057 4205 Manorwood Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 If Yes, Give Year or Dates: 1 ☐ Never Married 2 💢 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker <u>Own Home</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Adam Brzuchalski Elizabeth Haluch ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) N. Frank Lanocha husband 4205 Manorwood Drive; Glen Arm, MD 21057 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Commation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) entombment Dulaney Valley Mem Gardens 1/14/09 Timonium, MD 21. Signature of Funeral Service 22. Name and Address of Facility
RUCK TOWSON, Funeral H
1050 York Rd. Towson, 23a. Part 1. Enter the disease, or complicati shock, or heart failure. List only one that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 n 1 ☐ Yes 2 Month Day Year 5 Other (specify) ed by the detached f 9 Unknown 9 Unknow been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 2 10 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 2 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one 1 ☐ Yes 2 Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) SON \(\text{S} \) home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral Manner of eath Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and License number

State Registrar name and address of person who completed cause of death (Item 23a) (Type, Print)

Day, Year)

Registrar's Signature

3

Division or Vital Records, P.O. Box 68760. To the Hospital within 24 hours a To the Funeral I

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State

Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Canaway Rosentral mo

JAN 1 2 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

parket

Cosenthal, M.O., 608 Edgevale Road, Baltimore MD

29c. License number

D31025

29d. Date signed (Month, Day, Year)

AMEND, ITEM#10e, perfH G887, 1/12/09 WS State of Maryland, Bepartment of Health and Mental Hygiene Certificate of Death Reg. No. 2 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** David M. moune 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Streel 8. Date of Birth (Month Day Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Social Security Number **Funeral** Days Months Min 1X M 2 □ F 55 214-64-5566 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evan net must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location N/A MD Baltimore 1 XYes 2 □ No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 542 N Payson St 21223 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ᠫ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etcan 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No ^{Specify:}Americ an ģ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hospital Nurse 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robinson C. Moore, Sr. Ruth Rice ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robinson C. Moore, Jr. / Bro. | 3919 Glenhunt Rd, Balt., MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory 1/17/09 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Special) Balt.,MD 22. Name and Address of Facility Hari P. Close F. Svs, PA 5126 Belair Rd, Balt., MD 21206 21. Signature of Funeral Service Licenses or coordications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and yone cause on each line. 23a. Part 1. Enter the diseast Approximate Interval Between Onset and Death one cause on each line shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Cardinascular **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or a Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 NO 2 1 □Yes 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one. Hospital: 1 Yes 2 No Other: 4 \sum Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 ☐ Other (Specify) Certification: To 5 Tesidence this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? I or Attending Fafter death. Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29b. Signature and the of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N-EUGW 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 2 2009 Registrar

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State of Maryland / Department of Health and Mental Hygiene

iniothy Andrew		1- For State 1- For State Registrar State of Maryland / Department of Healt Certificate of Deatl		, ,	2009	0038
Physici Medical Exami	an/	Decedent's Name (First, Middle,Last)		2. Date of Death Month January 10		3. Time of Death 0528 hrs
neulcai Exaiii	Hei		Town, or Location of Dea		, 2009 4c. County of Death	00201115
			minster : er 1 Year If Under 24H	Im 19: Date of Birth	Carroll (MM/DD/YYYY) 9. Birti	polace (State or
Funeral Director		217-17-5869 1XM 2 F 21 Yrs. Months			Foreign	
d how any	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Carroll Sykesville				10d. Inside City Limits 1 Yes 2 XNo
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 10f. Zip 4413 Carroll Park Court 21	784	10	g. Citizen of What Coun	try?
er death wi , or items	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent In In In In In In In In In In In In In	ent of Hispanic Origin? (s fy Cuban, Mexican, Puer X No specify:		14. Race - Americ White, etc. Specify: blac	
215-0036 po filed within 72 hours after that Itygiene. ked other than "natural" end, the Medical Examine.	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) auto deale	Occupation (Give kind o rking life. DO NOT use re er worker		16b, Kind of Business/Ir automotiv	
21215-0036 wild be filed within 7 Mental Hygiene. marked other than cevent, the Medical	Be	Von A. Mahoney	Andene	ne (First, Middle, M Palmisar	10	
imore, MD 21. Pages I and 2 should then of Health and Meriant: If item 27 is marror or other traumatic even	7	19a. Informant's Name/Relationship (Type, Print) Ann Palmisano (mother) 19b. Mailing Address 4413 Carro 20a. Method of Disposition 120b. Place of Disposition (Name)	oll Park Ct	., Sykesv		1784
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and N Important: If item 27 is in injury or other traumatic.	Mark a	1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Crematory or other place)	emetery 1-	15-09	Sykesville	, MD
Bal permit Depart Impor		21. Signature of Funeral Service Licensee 22. Name and P.O.]	Address of Facility Ha Box 195 Syk	ight Fune esville.	eral Home & MD 21784	Chape1
Physician /Medical xaminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries	of dying, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of): b.				
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury draunitiateu events resulting in death). Last pure to (or as a consequence of):		it -		
and transit		d d				
60, are be exe	Medical	UNPENDED AMENDED				
Records, P.O. Box 68760, ————————————————————————————————————			3 Ectopic preg	nancy	23d. Date of delivery Month D	ay Y ear
ires that the signed by the bedetached	ρ		cause given in Part I.		pacco use contribute to t	
Division of Vital Records, tal or Attending Physician: The law require its after death. al Director: After this certificate has been sighed in by the funeral director, page 2 should be	Completed			24a. Was a autops perform	y prior to coned? death?	copsy findings available ompletion of cause of
tal Rec cian: The l certificate l	Be C	25. Was case referred to medical	26.Place of Death (Chec	· · · ·		2 10
ion of Vit tending Physic eath. toe: After this.	ပ္	1 Yes 2 No Position 1 Inpatient 2 ER/Outpatient 3 D	OOA Other'4 Nurs 28c. Injury at Work?	-	Residence 6 Other.	Scene
Division pital or Attend ours after death.	Certification:	1 Natural 5 Pending Investigation 3 Suicide 6 Could not be Suicide 1 Suicide 2 Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory,	1 Yes 2 ✓ No v, office building, etc.		treet and Number or Ru	al Route Number, City
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the		Route 32 South	n of Birdview Road, V	ed.
To th Withi To th	Medical	and manner stated.	c. License number	at the time, date a	29d. Date signed (Mon	
	-	CarolHallan	O.C.M.E.		January 10, 2009	
U		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, E	Baltimore, MD 212	201		
St Regis	tate trar	* A A A A A A A A A A A A A A A A A A A	9			
DHMH 17 Rev 1/2	001	OCME ORIGINAL				

	1	For State Registrar	State of Maryla		Certifica				Reg. No.	2009	003	82
D		1. Decedent's Name (First, Middle, La	st)					2. Date of De Month	-	Year	3. Time of D	eath
Physici /Medio		Stella Musick						Januar		, 2009 ^r	3:23 A	7. W
Examir	er	4a. Facility Name (If not institution, give			4b. Cit		r Location of Dea	ath	ac. County of Death Baltimore Count			
C		Stella Maris Hosp 5. Social Security Number 6.5		. last birth	dav) If Und	er 1 Year	Ollium If Under 24 Hr	s. 8. Date of Bir	th	9 Birthr	place (State or	Foreign
Funeral Director	1		Sex 7. Age (In yrs	1 _Y	rs. Month	s Days	Hours Mir	sept.0	9,19	17 Mine	rsville	PA.
>		Usual Residence of Decedent	140-0	da . Tarres	- Lootin		1			14	I0d. Inside City	Limito
ed other than "natural", or items 23a or 28a-f show event, it e Medical Everthan runst be rediffed at	7	10a. State 10b. County Maryland Baltimo		aldwi	or Location					'	1 ∐Yes 2	
1	Funeral Director	10e. Street and Number	Te country 130	a i dvv i		ip Code			10g. Citiz	zen of What Cour		
T S		16 Carroll Meadow	s Drive				21013		-	ited Sta		
9	nera	11. Marital Status	12. Was Decedent Ever in U	J.S.	13. Was Dec			(Specify Yes or No rto Rican, etc.)		14. Race - Americ	can Indian,	
N P		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ♣ No If Yes, Give		ir res, sp 1 ∐Yes	3.7	Specify:	erto Hicari, etc.)		Black, White, Specify: Wh	etc. ite	
Exa	d b	3 Ñ Widowed 4 ☐ Divorced	Year or Dates:									
edica	lete	15. Decedent's E (Specify only highest gr	ade completed)	16a. L	Decedent's Us Give kind of v life DO NOT	ual Occup vork done use retirei	pation during most of w d)	orking	160. Kir	nd of Business/In	dustry	
vent, the Ma	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)			stre]]	London F	'og	
vent,	Be C	17. Father's Name (First, Middle, Last)					ame (First, Middle	, Maiden	Surname)		
	2	Simeon Polinsky					Maria	Stoppie				
or otner traumatic		19a. Informant's Name/Relationship Mr. Ronald L. Mus					and Number or I	Rural Route Numb	-	r <i>Town, State, Zip</i> in, Mary		21013
		20a. Method of Disposition			Disposition (N		Sadows L	Date		cation - City or To		.101
5		1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery	crematory of	other plac	1 10	n.12,		timore,M		3
any injury or other tra once.		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lies	97	7				009 '				
any ir	3	12/Am -A	- Havo	n	2325	York	Road	ves Fune Timoniu	n, Ma	aryland	21093	P.A.
		23a. Part . Erver the disease, or conshock, or heart failure. List only	plications that caused the dea	ath. Do no	ot enter the m	ode of dyir	ng, such as cardi	ac or respiratory a	arrest,		Approximate Interval Between	
cian		Immedia e Cause (7 in 1) disease or condition	a DEMENTIA								Onset and De	atn
ical ner		resulting in death)	Due to (or as a conse	quence of):							
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l-transit	xamine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	•									
	ш	resulting in death) Last	Due to (or as a conse	quence of):							
	lical		d									
for use as the buria	Physician/Medical	IF FEMALE:	23c. If yes, outcome of pregi	nancv								
l for u	cian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No	1 Live birth 2 Fe	tal death	3 ☐ Ectopic 5 ☐ Other		;y		1	23d. Date of delive Month	Day Ye	ar
be detached t	hysi	9 Unknown	9 ☐ Unknown								_	
	by P	Part II. Other significant conditions	contributing to death but not re	sulting in	the underlying	cause giv	en in Part I.		_	se contribute to t		
should	ted							- 10	Yes 2	No 3 Prol	bably 4 ☐ Un	known
20	Completed							24a. Was	DSV	prior to co	ppsy findings av impletion of cau	railable use of
pag								1 □ Yes	ormed? 2 X No	death? 1 □ Yes	2 🗆 No	
director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2X No	Hospital:	7.50/0		Oth		eath (Check only		V	посрт	CE
funeral d	n: To	27. Manner of Death	1 Inpatient 2 [28a. Date of Injury	28b. Ti	me of	28c. Inju	ry at	Home 5 Res			y, HODI I	OH.
9	atio	1 X Natural 5 ☐ Pending investigation		inj	ury M	Wor 1 🗆	k? Yes 2 □ No					
n by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		home, farr	n, street, facto	ory, office		28f. Location (Cify or To	Street and wn, State)	d Number or Rura	al Route Number	9 <i>r</i> ,
completely filled in by the		29a. Certifier 1 ☐ Certifying P	hysician: To the best of my kr	nowledge	dooth coo	nd at the A	imo date and sis	on and due to the	001120(-)	and manner of	ntated	
>	edical		miner: On the basis of examin									
completel	5		titaloner stated.		, or mireongen	o,y			, date and	pidoo, dila doo i	(-/	

State Registrar 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093
32. Registrar's Synature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACKIE JONES, CRNP
31. Date filed (Month, Day, Year)
JAN 1 2 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Thomas Irving Miller 4:50 P M 2009 January 8, /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Stella Maris Timonium If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 ☐ F 212-94-8057 Yrs. Director 1965 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits mportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Parkville Parkville MD Baltimore Director 1 ☐ Yes 2√ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 6 Fitzgerald Court Apt H Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo 2 Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Catering Restaurant 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Irving Bernard Miller Regina Agnes Koscielski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cristine M. Miller / Wife 6 Fitzgerald Court Apt H Parkville, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Serv. Corp. 1/10/2009 Towson, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Towson, Maryland 21204 lell Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that canted the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PANCREATIC CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine Cause (Disease or injury that initiated events resulting in death) Last physician and the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗌 No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed? (es 2**X** No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: ${}_{4} \square$ Nursing Home ${}_{5} \square$ Residence ${}_{6} X \square$ Other (Specify) **HOSPICE** 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation 1X Natural Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifier (Check only one) X Nurse Practitionary To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Nurse Practitionary Medical 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 1/9/2009

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records,

To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica

THOMAS MILLER

permit. Pages 1 and 2 should be 1 Department of Health and Mental Important: If Item 27 is marked o

DHMH 17 Rev 1/2001

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JENNIFER HAUF.

JAN 1 2 2009

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Mary	land / Dep		Health and	Mental Hyg	_	a nnaal		
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last) Margaret Lee M 4a. Facility Name (If not institution, give s Gilchrist Hosp	street and number)			or Location of Dea		y 11 , 200 4c. County of De	9 2:32 A ^M		
	Funeral Director		5. Social Security Number 6. Sex 213-42-4940	7. Age (III	yrs. last birthday, Yrs.	Months Days		. (Month, Day	9. E	Birthplace (State or Foreign Country) Maryland		
	within 72 hours after death with the Maryland lene. 'than "natural", or items 23a or 28a-f show he Midrol Evar, in the final per politied at	Director	MD 10b. County Baltime		c.City, Town or Lo	erstown				10d. Inside City Limits 1 □Yes X [X]No		
	a or 2	Dir	13 Waugh Ave.			10f. Zip Code	21126		10g. Citizen of What			
	ns 23	era		12. Was Decedent Ever	r in U.S. 13.	Was Decedent of	21136 Hispanic Origin? (Specify Yes or No- rto Rican, etc.)	U.S. A	A • merican Indian,		
9800	72 hours after death with the Marylar instural", or Items 23a or 28a-f show digal Examinational Le profiled at	Completed by Funeral	1 Never Married 2 Married XX Widowed 4 Divorced	Armed Forces? 1		If Yes, specify Cul 1 □ Yes 🏋 No		rto Rican, etc.)	Black, Wi			
Maryland 21215-0036	ithin 72 ho ne. han "natul	mplete	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e co <i>mpleted)</i> College (1-4or 5+)	(Give		e during most of wo ed)	orking	16b. Kind of Busines			
12		S	12 17. Father's Name (First, Middle, Last)		Ва	r Tend		ame (First, Middle,	Restau	rant		
anc	be intal) Be	Gordon Ebley					dred Th				
ary	2 should be and Menta Is marked aumatic ev	2	19a. Informant's Name/Relationship (Typ	pe. Print)	19b. Maili	ng Address (Stree			Omas r, City or Town, State	e, Zip Code)		
	1 and 2 Health a em 27 Is		Janon M. Chilcoat	t/Friend	13	Waugh i	Ave. Re	isterst	own, MD	21136		
Baltimore,			20a. Method of Disposition	omoval from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ace)	Date	20c. Location - City	or Town, State		
Ë	mit. Pages partment of lorant: If ite ortant: If ite linjury or of lorant: E.		1 X urial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (<i>Specify</i>)			ts Ceme				stown, MD		
Bal	permit. Pages Department o Important: If i any Injury or once.		21. Signature of Furieral Service License	self	11	605 Rei	stersto	wn Rd. C	wings Mi	Chape1 P.A. 11s,MD2111		
,092	eath certificate be executed attending physician and tor use as the burial-transit	dical Examiner										
.O. Box 68	that the death certifica led by the attending pr detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnar ☐ Other <i>(specify)</i>			23d. Date of Month	delivery Day Year		
rds, P.	w requires that s been signed k should be deta	þ	Part II. Other significant conditions conf	tributing to death but no	ot resulting in the u	ınderlying cause g	iven in Part I.			e to the cause of death? Probably 4 🗹 Unknown		
l Rec	2 2 2	Completed	OF Was sacrationed to medical					1 □ Yes	med? prior death			
f Vit	Physician: rthis certific ral director, I	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	2 ☐ ER/Outpatie	nt 3 DOA	hor:	eath (Check only or Home 5 Resid	ne) ence 6 ☑Other(S	pecify) HOSPICE		
sion o	ding Fune	Certification: To	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Ye	28b. Time of Injury	Wo	ury at ork? □Yes 2□No	28d. Describe h	ow injury occurred			
Divis	e Hospital or Atten 24 hours after death Funeral Director: etely filled in by the	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, st Specify)	reet, factory, office		28f. Location (S City or Tow		Rural Route Number,		
)	Hosp 24 hou Fune stely fil	Medical	29a. Certifier (Check only one) 1	ilclan: To the best of m	amination and/or in	th occurred at the rvestigation, in my	time, date and pla opinion, death oc	ce, and due to the courred at the time, o	cause(s) and manner date and place, and c	r as stated. due to the cause(s)		
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licer	nse number		29d. Date signed (Mo	onth, Day, Year)		
	1		MAM	Allen.	uno	_						
0	3		30. Name and address of person who cor	mpleted cause of death	(Item 23a) (Type,	Print)	t. Ba	Go. ms	Jenuary 2, 20%	= ' '		
	Sta Registra		31. Date filed (Month, Day, Year) JAN 1 2 200	32. Aegistrar's		all				-,,,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-00206 State of Maryland / Department of Health and Mental Hygiene James Albert McNair, Jr. Certificate of Death 1- For State Rea. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month: January 7, 2009 1520 hrs **Medical Examiner** James A. McNair Jr 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number **Baltimore County** Windsor Mill 17 Farmington Court 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or . If Under 24Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) oreign MD **Funeral** Months Davs Hours Min. Country) Director 219-40-4222 65 Jan28,1943 $_{1}$ X_{M} 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State XIO Yes 2 23a or 28a-f show notified at once, Baltimore Baltimore Imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 17 Farmington Ct. 21244 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, uneral 12. Was Decedent Ever in U.S. 11. Mantal Status White, etc items Armed Forces? 2 Never Married XYes No Black 9 Specify: Yes 2 X No specify: If Yes, Give Year Vietnam Widowed 4 X Divorced "natural" à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) pleted College (1-4 or 5+) Elementary/Secondary (0-12) uniatic event, the Medical lyr National Auctionaire Car Mover Com 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) McNair Sr. James A. Mozell 27 is marked Crudup 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Meadow Heights Balto Brian McNair/Son Md ent of Health a nt: If item 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition timore. crematory or other place) Owingsmills, Md 1 X Burial 2 Cremation 3 GarrisonForestVetCemJan16,2∮09 i Iment tant: Donation 5 Other Specify 22. Name and Address of Facility
CALVIN B. SCRUGGS F
1412 E. PRESTON ST. 21 Signature of Funeral Service Licensee MD 2121
Approximate Interva 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Between Onset and Physician failure. List only one cause on each line Death Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last g887 1/20/09 put per FD hysician/Medical X AMENDED physician a UNPENDED To the Hospital or Attending Physician: The law requires that the death certificate be-23d. Date of delivery P.O. Box 68760. 23c. If yes, outcome of pregnancy IF FEMALE: Year 3 Ectopic pregnancy Month Day 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown detached for Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ▔ Yes 2 No 3 Probably 4 V Unknown 5 Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an has been prior to completion of cause of autopsy death? performed? No Yes 2 V No page 26 Place of Death (Check only one) 25. Was case referred to medical Be examiner? Residence 6 V Other: Scene Hospital: 1 Nursing Home 5 FR/Outpatient 3 Inpatient 2 this 1 ✓ Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death After Certification 1 V Natural Yes 2 No Pending within 24 hours after death. Director: Investigation 2 28f. Location (Street and Number or Rural Route Number, City Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 Suicide determined (Specify) To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29c. License number

31. Date filed (Month, Day, Year) State JAN 1 9 2000 Registrar

29b. Signature and title of certifie

Pamela E. Southall, MD

30. Name and address of person who completed cause of death (Item 23a)

32. Registrar's Signature

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

January 8, 2009

amend #9 Per FH g8g/ 1/15/09 JH ck Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year HUBERT NORRIS JANUARY 2009 1600 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 X M 2 □ F ELWH Director 247-46-9187 DEC. 1932 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show or items 23a or 28a-f sho 1X Yes 2 No Director DC WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 900 5TH STREET, SE #248 20003 Funeral USA filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married altimore, Maryland 21215-0036 ö 1 ☐ Yes 2 📉 No Completed by Specify: event, the Medical Exa 3 Widowed 4 Divorced "natural" BLACK 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CHEF PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked of Be and 2 should be OLIVER P. NORRIS LETTIE NOLA SPEARS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health UZELLIA HOWELL / SISTER 4243 LANE PL, NE WASHINGTON, DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State WASHINGTON NATIONAL 4 ☐ Donation 5 ☐ Other (Specify) 01-09-2009 | SUITLAND, MD 21. Signature ungral Cruice Licensee 22. Name and Address of Facility MARSHALL S FUNERAL HOME OF MD DONALD R. GRAY 4308 SUITLAND ROAD SUITLAND, MD 23a. Par 1 Enter the diseas shock, or heart failure. Immediale Cause (Final disease or condition resulting in death) complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death KeNAL STAGE **Physician** /Medical Due to (or as a consequence of): Examiner Pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for se's nonsequence of: or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit MeunTus 214BETES Due to (or as a consequence of): Box 68760. 31SEAS E Physician/Medical Oron Mrc attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) P.0. signed by the a 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an certificate 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? After Division 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and 29d. Date signed (Month, Day, Year) 2009 30. Name and address of person who completed cause of de (Type, Print) DENKIN 600 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State Registrar park.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 00387 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** Nedl 1:10 PM Januar 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Jan. 3, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
_____ **Funeral** 1□M 2√F Jan. Yrs. 172-52-4192 48 1961 PA Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner mines. 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 500 Painted Wood Drive 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗓 No þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Software Engineer Computer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul Nedley Shirley Krotz ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 500 Painted Wood Dr., Sykesville, MD 21784 Mr. Dennis L. Wisebaker (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial A ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) All County Cremation 1/11/2009 Svkesville, MD 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, P PO Box 195 Sykesville, MD 21784 Pargy Hargut Herbert 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Herniahon Iranstentorial **Physician** /Medical Due to (or as a consequence of): Examiner Brain thoxic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Ulmonari Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Inpatient 2 [
Date of Injury (Month, Day Year) 1 🗌 Yes 2 2 ER/Outpatient 3 DOA 27. Manner of Death 1. Natural 28a. 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Res-000 10,2004 MOMPH January 7

State Registrar

DHMH 17 Rev 1/2001

; Johns Hopkins Hospital, 600 North Welfe Street; Bulhnure Maryland 21287

address of person who completed cause of death (Item 23a) (Type, Print)

recki momph

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

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Registrar DHMH 17 Rev 1/2001

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22. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Major Paylor, Sr anuare /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death County of Death Examiner Maryland Baltimore NA ntal Greneral If Under 1 Year | If Under 24 Hrs. (In yrs. last birthday, Social Security Number 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 246-52-7772 70 N.C. Director 8-11-1938 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director MD N/A Balto 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 Items 23a 1206 Ensor Street Funeral 21202 S Α 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married "natural", or 1 ☐ Yes 🎇 No Black Specify: þ 3 ☐ Widowed 4 🎇 Divorced Completed 16b. Kind of Business/Industry unk 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Brick Mason is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Fannie Stephens Neatom Paylor 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai Fannie Paylor-Daughter 1108 N. Stricker Street Balto, MD 21217 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 13-2009 Rexboro, N.C. 21. Signature of Funeral Service Licensee March East F/H Wane 1101 Ε. North Avenue 21202 Balto, MD 9 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ingemia Sequentially list conditions, france in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine fficile Colitis death certificate be executed attending physician and for use as the bunal-transi Due to (or as a consequence of): Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I ☐Yes 2☐No the detached 9□Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 Yes 2 No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy perform page ; After this certificate or Attending Physician; Be 25. Was case referred to medical 26. Place of Death Check onl one examiner? Other: 4 \(\text{Nursing Home} \) 1 \(\text{Pecify} \) 1 Tyes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural
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Registrar

DHMH 17 Rev 1/2001

Maryland

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Vadi,

31. Date filed (Month, Day,

09

State of Maryland / Department of Health and Mental Hygieney 00392 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 January Allen Parezo 8:05 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 16112 Laurel Ridge Drive Laurel 8. Date of Birth (Month, Day, Year Sept. 14, 1929 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 🛣 M 2 🗆 F 579-34-8812 Washington, DC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State ed other than "natural", or Items 23a or 28a-f show event, the Midical Exameter must be notified at 1 ☐ Yes 2XX No Director Maryland Prince George's Laurel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20707 U.S.A. 16112 Laurel Ridge Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (SpecIfy Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2½ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Improvement Contractor . Pages 1 and 2 should be filed wir Iment of Health and Mental Hygier tant: If Item 27 Is marked other th Jury or other traumatic event, Ital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lawrence Parezo Edith Kopp ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jean Parezo (Wife) 16112 Laurel Ridge Drive Laurel, Maryland 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Atlantic Crematory 5 ☐ Other (Specify) 1-5-2009 Glen Burnie, Maryland 4 ☐ Donation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home, Inc 7601 Sandy Spring Road mv080 Laurel, Maryland 20707 Approximate Interval Between Onset and Death 23a. Bart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 6 Ran /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of) law requires that the death certificate be executed burial-transi Exami Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year 5 Other (specify) P.O. hed by the a a I Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by Yes icate has been si 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy certificate 1 □ Yes 2 After this certification funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 1 ☐ Yes 2 ☐ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Manner of Death 28d. Describe how injury occurred Hospital or Attending Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No n 24 hours after death.

The Funeral Director: A pletely filled in by the filled in th investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (Ri DO 22. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Athent known as Robert P. Honan Baltimore. Marvland 21215-0036

		•	For State Registrar		ryland / Depa	artment of F rtificate of		and Mer		ene2009	00393	
	Physicia	an	1. Decedent's Name (First, Middle, Las	t)					Date of Death Month	Day Year	3. Time of Death	
_	/Medic		Robert Pittman						morry	4 2009	12:56 AM	
* 1	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, o		f Death		4c. County of Dea	th	
140 M	Funeral		5. Social Security Number 6. Se		(In yrs. last birthday)	If Under 1 Year	If Under 2	24 Hrs. 8.	Date of Birth (Month, Day,	9. Bir	thplace (State or Foreign	
	Director		421-20-4782	M 2□F	82 Yrs.	Months Days	Hours		(Month, Day, ec 31,		ountry) ibama	
	p. ,		Usual Residence of Decedent		10 00 7							
	arylar show	_	10a. State 10b. County		10c. City, Town or Lo						10d. Inside City Limits 17√2 Yes 2 □ No	
d 21215-0036	he M 28a-f	Completed by Funeral Director			Darti	10f. Zip Code			10	g. Citizen of What Co		
	be flied within 72 hours after death with the Marylan Hygiene. Hygiene, et d'ether than "natural", or items 23a or 28a-f show event, the Medical Evarther must be notified at		10e. Street and Number				01000		10		ountry?	
	ns 23		1651 E. Belvedere	12. Was Decedent E	ver in U.S. 13.		21239 Hispanic Orio	nin? (Specify	Yes or No-	USA 14. Race - Ame	erican Indian.	
	riter d		1 Never Married 2 Married	Armed Forces? 1 XXYes 2 □ No	0	Was Decedent of H		Puerto Rica	an, etc.)	Black, Whit	e, etc.	
	al",o		3 ☐ Widowed 4 🔀 Divorced	If Yes, Give Year or Dates:		1 □Yes 2XINo	Specify:			Specify: wh	ite	
	natur		15. Decedent's Edi (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occup kind of work done	during most	of working	1	6b. Kind of Business	/Industry	
12	vithin nne. han '		Elementary/Secondary (0-12)	College (1-4or 5+	-)	DO NOT use retire	d) -					
N D	iled v Hygie ther t		17. Father's Name (First, Middle, Last)	0	we.	lder	18. Mother	r's Name <i>(Fi</i>	rst. Middle. M.	Kaiser A		
au	d d d) Be	17. Taulot S Haine (7 no., mode, zably			unk	10. Modilo	i o riamo (i r	,	arour carriarito,	unk	
Maryland	should be and Menta is marked aumatic en	٩	19a. Informant's Name/Relationship (7	ype. Print)	19b. Mailir	ng Address (Street	and Numbe	r or Rural Ro	oute Number.	City or Town, State,	Zip Code)	
≥ .	and 2 and 2 and 2 and 2 and 2 and 27 is		Suzette Pittman/d			Churchil			Bel Ai	-		
<u>.</u>	es 1 ar of Hea fitem rothe		20a. Method of Disposition		20b. Place of Dispo		;	Date		Oc. Location - City or		
Ê	Pages nent of int: If It iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 🖾 Donation 5 ☐ Other (Specify		cemetery, crer	natory or other plac						
	permit. Pages 1 and 2 should I Department of Health and Men Important: If Item 27 Is marke any Injury or other traumatic once.		21. Signature of Euneral Service Licens	19/	cterr St	2. Name and Addre	ess of Facility	hard 6	55 t./ 1	Poltimroo	Ctuant	
m	99 = 69		Ronald S. Wader Director State Anatomy Board 655 W. Baltimroe Street Baltimore, MD 21201									
E	death certificate be executed Wedical e attending physician and d for use as the burial-transit	J.	23a. Part 1. Inter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between									
			Immediate Cau (Final disease or condition						Onset and Death			
			resulting in death)	Due to (or as a	conseq ence of):	111						
			Sequentially list conditions,	b. Due to for so a								
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Ener underlying Cause (Disease or injury	consequence of):	Juence ot):							
		xar	that initiated events c			ence of):						
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Вох	h cer endin use a	Certification: To Be Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	of pregnancy 2 □ Fetal death 3 [death 3 Ectopic pregnancy				23d. Date of delivery Month Day Year			
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ec	has b]	24a. Was an autopsy	prior to	utopsy findings available completion of cause of	
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o	Phys this ral dir		1 ☐ Yes 2 ♣No 27. Manner of Death	1 A Inpatier 28a. Date of Injur	nt 2 ER/Outpatien	III 3 LI DOA	4 🗆 Nu!			nce 6 Other (Special of the Control	ecify)	
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<u> </u>	to the rospital of Attending Prystcian: The law requires that the within 42 hours after the second to the Tuneral Director; After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	erti	4 ☐ Homicide determined	. (Specify)								
1		Medical C	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	in 24 he Fu pletel		(Check only 2 Medical Examone)	and manner stat	ted.	ivestigation, in my (opinion, deal	ın occurred a	ıtne time, da	te and place, and du	e to the cause(s)	
. 1	Vith Vith Com	Σ	29b. Signature and title of certifier			29c. Licens	se number		29	d. Date signed (Mon	th, Day, Year)	
			Pariste HD			7ES-00	00			enune 4 200	01	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
			Pamela Denisse HD 31. Date filed (Month, Day, Year)	Sinai Hospital	& Balhmore	<u> </u>						
	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 2 2009	2. riegistra	A Am	Kel						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc g887 1-12-09 vt. State of Maryland / Department of Health and Mental Hygiene 00394 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5, 2009 Month 4:51PM M Stanley R. Redwood January 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1**X** M 2 □ F 79 579-54-6596 June 20, 1929 Jamaica Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Lutherville MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4 A Broadridge Lane 21093 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Black. 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Social Worker State of MD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rufus Redwood Eugena McDonald 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvia Redwood Wife A Broadridge Lane, Lutherville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) South Carroll Crem. 1/8/09 Winfield, MD 22. Name and Address of Facility 11824 Reisterstown Road 21136 Wayne Osterling | Eline Funeral Home Reisterstown, MD nt 1. Enterwhe diseas hock, or heart favure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Approximate Interval Between immedition disease or contition resulting in death) CARDIAC ARCHITHMIA Due to (or as a consequence of): Congestive her 4 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Huneviensian 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, cate has been signed by the page 2 should be detached within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, the

Physician

Examiner

Funeral Director

Completed by

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Physician/Medical

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Medical Certification: To

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Widon Event in a natural be putified at once.

Physician

/Medical

/Medical

State Registrar

Dr Harry W. Kaplanino 31. Date filed (Month, Day, Year) - w

29b. Signature and title of



m

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

certifier

29c. License number

D40371

29d. Date signed (Month, Day, Year)

116109

BAUTIMONE, MO

		-	For State Registrar	State of Mary	-	rtificate of l		lentar r ry	Reg. No. 2	009	00395
П	Physicia	an	1. Decedent's Name (First, Middle, La	ROSNER				2. Date of Dea	Day	2009	3. Time of Death 0738AM
	/Medic Examin		4a. Facility Name (If not institution, give	ve street and number)		4b. City, Town, gr	Location of Death			unty of Death	
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month Day Year						v. Year)	9. Birthpl	ace (State or Foreign	
	Director		2/3 32/95/ 1 M 20 F 7 3 Yrs. Months Days Hours Min. Month, Days Fourty NJ Usual Residence of Decedent								
5-0036	aryland show	ō	10a. State 10b. County MD BALTI		c. City, Town or Lo			_		10	d. Inside City Limits 1 ☐ Yes 2 🛣 No
	h the N or 28a-f	Director	MD BALTIMORE 10e. Street and Number		BALTIMORE 10f. Zip Code				10g. Citizen of What Country?		
	hours after death with the Maryland ural", or items 23a or 28a-f show at Examiner must be notified at	Funeral D	2 POMONA EAST,	#509	in II S 13 \	2120		ecify Yes or No	- 14	USA Race - America	n Indian
	n / 2 mours after death with the wat year "natural", or items 23a or 28a-f show odical Examiner must be motified at	Ď	11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	I .	if Yes, specify Cuba 1 □Yes 2 🛣 No	lispanic Origin? (Spi an, Mexican, Puerto Specify:	Rican, etc.)	Sp	Black, White, e	tc. E
	within 72 hours af iene. than "natural", or he Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		(Give	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind	of Business/Ind	ustry
שַׁל	wil the lieu		Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last		PRE	SIDENT	18. Mother's Name	/First Middle		SNER ELE	CTRIC
	A 2 5	To Be	LEONARD BARRO		RRON				GILZENBERG		
Mar	th and I		19a. Informant's Name/Relationship RUBIN ROSNER / H	(Type. Print) IUSBAND			and Number or Run		-		
ore,	permit. Pages 1 and 2 should be Department of Health and Mente Important: If item 2 Tis marked any injury or other traumatic e once.		20a. Method of Disposition 1 Disposition 3 Company					DALITIN		tion - City or Tov	
Baltimore,	nit. Pag artment ortant: I injury o		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice			EL 2. Name and Addre		9/2009		ΓΙΜΟRE, & BROS.,	
n n	Dep and and and and and and and and and and	2 1	Robert /	Z	_		STERSTOWN				
Tree.	Dhsisis		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.			10				Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Heriscleronc Coronary Disease Due to (or as a consequence of):								
	Examiner	Je.	Sequentially list conditions,	b	neeque nee of):						
	and transit	Examiner	day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	consequence of):							
68760,	rtificate be executed ng physician and as the burial-transit	edical E		d	insequence on.						
			IF FEMALE:	23c. If yes, outcome of pr	regnancy				224	A Data of delive	
P.O. Box	requires that the death cert seen signed by the attendin- hould be detached for use a	Completed by Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)					230	I. Date of delive Month	Day Year
Records, F	v requires that the debase been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 44 Unknown		
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Vita	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient	2♠ ER/Outpatier	nt 3 🗆 DOA Oth	26. Place of Deather: 4 ☐ Nursing Ho			Other (Specify	•)
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Division of	dear dear ctor y the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	e Hospital or / 124 hours after e Funeral Dire letely filled in b		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
	To the Hospital or within 24 hours after To the Funeral Directory filled in b	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date s	signed (Month, L	Day, Year)
	-) Sand		//h 00 \ T	D00	5763	9	JA	N 08	2009
	i0		30. Name and address of person who	raud, m	(Item 23a) (Type, 54	101 Blo	1 Court	Rd K	and	allstou	2009 2009 NMD21133
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's S	Signature /	parket					d d

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Himore lhmor If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** 1√2 M 2□ F Months Days Hours Min. 75 219-28-5055 Director 8-26-1933 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, I'm Medical Evanimer must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Director MD N/A 1 XYes 2 ☐ No Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 727 E. Preston Street 21202 U S Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 2 Specify: Black ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) City of Baltimore N/A llth grade Sanitation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Cromwell Mary Barnes ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracy Savoy-Daughter 727 E. Preston Street Balto, MD 21202 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pages Department o Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Memorial Pk 1-13-2009 King Randallstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H undro 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** Myocardia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Zhours coronary prtery Sequentially list conditions Examiner if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): Box 68760. physician Physician/Medical as. attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) ned by the a Ö 9 Unknown 9 Unknown <u>م</u> cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 🗆 No Division of Vital 2 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗆 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) BC9425574 M.O. 30. Name an address of person who complete cause of death (Item 23a) (Type, Print) Center 301 St. Paul Place, Baltimore mo 2/202 130:AN Cornel Mercy Registrar's Signature 31. Date filed (Month, Day, Year) State Registra

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

2009

TANUARY

CATASTELLA

STAUDENMAIER,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 00398 Reg. No.2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year **Physician** 20:02 PM ANUART 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RBOR BAL WOKE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1**X** M 2□ F Yrs. Director 12/29/1950 214-52-8517 58 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f shore Examiner must be notified at Director 1 XYes 2 ☐ No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 U.S.A. by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 203 Midland Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: Black 3 Widowed 4 Divorced "natural" Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 12 Grocer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked c Harold Agustus Sanders Carrie Rush 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if item 27 is any injury or other trau once. 203 Midland Avenue, Baltimore, Maryland of Date 20c. Location - City of Da Mildred Sanders / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/16/2009 Lansdowne, Maryland Zion Cemetery 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. ature of Funeral S e License 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ONE MONTH /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine al or Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and I birector page 2 should be detached for use as the burlia-fransit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 1 No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled filled Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

IAN 1 2 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

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29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 8 Steven **Physician** Stewart Warne ANUar /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Town, or Location of Death Examiner Seasons Hospice - NW Hospita Baltimore andalistown 8. Date of Birth (Month, Day 12 14 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min Months Days Hours 220.94.417 1 M 2□ F MD L12 Yrs. Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore 1XYes 2 ☐ No MD Director 10f. Zip Code Street and Number 10g. Citizen of What Country? 21229 Nottingham USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 □Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2XNo Specify ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 010 GUP Elementary/Secondary (0-12) College (1-4or 5+) Devator Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Stowart ၉ James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Milford Mill Road Windsor Mill, MD 21244 James E. Stewart Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Windsor Mill, MD Park Cenetery 14109 a 4 Donation 5 Dother (Specify) Vandan C. Greene Funeral services 22. Name and Address of Facility 21. Signature of Funeral Service Lice Vaux Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SMALL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Property After this certificate has been signed by the attending physician and Due to (or as a consequence of): signed by the attending physician I be detached for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ Unknown 2 No 3 Probably certificate has been s irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy 1 □ Yes 🏂 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Cher (Specify) HOSPice 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

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State Registr<u>ar</u>

31. Date filed (Month, Day, Year)

2835 Smith 32. Registrar's Signature Jack

ho completed cause of death (Item 23a) (Type, Print)

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Suite 203

BAltimore NO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of faryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar 00400Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Harry M. Siegle, Jr. 9:00P M 6,2009 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dundalk 75 Del Rio Road Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1⊠M 2□F 216-12-0623 -26-1923 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Dundalk 1 XYes 2 No Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21222 75 Del Rio Road Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married 1□Yes 2ĔNo Specify White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Trucking Truck Driver 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth Nelson Harry M. Siegle, Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 Wise Avew, Dundalk, MD 21222 Barry Jozwick - Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Xremation 3 ☐ Removal from State Atlantic Crematory 1-9-2009 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Lit PA, 2134 Willow Spring Road, 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ne Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 200 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide

Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Division or Vital Records, P.O. Box 68760, physician After 1

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Certification: To Medical

within 24 hours a To the Funeral C 6+1

State Registrar

determined

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Image: Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) JAN 1 2 2009

4 ☐ Homicide

29a. Certifier

\$2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND of Maryland Pepariment of Health and Mental Hydrene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 2009 Shirley Sharp Smith 1:30 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Carroll County 23 Thomas Schilling Court Upperco 8. Date of Birth (Month, Day, Year) Oct. 29, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 🗓 F 011-20-9748 1920 Conn. 88 Usual Residence of Decedent Baltimore Carroll County 10c. City, Town or Location 10d. Inside City Limits Maryland Upperco 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23 Thomas Schilling Court 21155 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: white 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick A. Sharp Arlene F. Jenks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Deborah S. Speed - daughter 23 Thomas Schilling Court Upperco, Maryland 21155 20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation 20a. Method of Disposition Date 20c. Location - City or Town, State Jan. 12, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licens M01072 934 South Main Street Hampstead, Maryland 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) bro vascular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Hospital: 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Name of Deat 1 X Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

the death certificate be executed Box 68760, Records, P.O. Division or Vital

and physician attending p ed by the a has page 2 certificate To the Hospital or Attending death. To the Funeral Director: completely filled in by the hours after 24

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show dica! Examiner must be notified at

Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the once.

Physician /Medical

Examiner

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Physician/Medical

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Completed

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Certification: To

Medical

1 and 2 should be Health and Mental

Pages 1 and 2 should I

Director

Funeral

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Completed

Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, Year) JAN 12 2009

29b. Signature and title of certific



and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician January 10, 2009 Roy Lee Snow, Sr. 3:26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Baltimore Towson 5. Social Security Number if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 27, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 ☑ M 2 □ F Hours West Virginia 305-22-3446 85 Director 1923 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eatth and Mental Hygiene. 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Wildian Evan increment by notified at Funeral Director 1 ☐ Yes 2 ☐ No Baltimore MD Towson 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a or 3 8101 Bellona Avenue 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No \$ Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supply Officer U. S. Government Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Snow ည Margaret Akers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 ls Lee Snow 7042 43rd Avenue E.; Palmetto, FL 34221 son permit. Pages 1 a
D partment of Her
Inportant: if item
any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donatio 5 ☐ Other (Specify) Dulaney Valley Mem Gardens 1/13/09 Timonium, MD 21. Signature of Fune al Se 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or compli priors that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only of a cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Welks . Physician monary /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an perform 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Natural 5 ☐ Pending investigation January 3, 2009 Kinknown M neral Director: / 2 Accident 1 ☐ Yes 2 ☑ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office, building, etc. (Specify) 8101 Bellong Ave 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8101 Bellonn Ave determined 4 Homicide Arden Courts Assisted Living Towsen, in 0 3120x within 24 hours a Towson, MO 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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6701 N. Clean

JANUMY 10, 2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) HAMOTARY 2009 01:30p M Scott Wales Mae 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution give of rectand number) Center imore 9. Birthplace (State or Foreign Country) Minnesota 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 19 6. Sex Hours Months Days 1 □ M 2 🛣 F Aug. 70 225-50-8234 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Baltimore Phoenix Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21131 USA 14308 Robcaste Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 ☐Yes 2**X**☐ If Yes, Give Year or Dates: 1 Never Married 20X Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cecelia Rauckman Hubert Wales 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14308 Robcaste Rd. Phoenix, Maryland 21131 William A. Scott/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1/12/09 Marysville,Pennsylvania Chestnut Grove Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC NON-SMALL CELL LUNG CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of, Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 🗆 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show

Funeral Director

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.

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Health and Mental em 27 Is marked o

: If item 27 or other t

Department or Important: If any Injury or once.

Baltimore, Maryland 21215-0036

/Medical

10a State

Examine the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mipletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician/Medical \$ Completed Be Certification: To in 24 hours.
the Funeral Directory filled in

Division of Vital Records, P.O. Box 68760

IF FEMALE 23b. Was decedent pregnant 25. Was case referred to medical examiner?

29a, Certifier

Medical

24a. Was an autopsy performe 1 ☐ Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 No

2 **X**No 1∐Yes 27, Manner of Death 1 Matural 2 Accident 3 ☐ Suicide 4 ☐ Homicide

5 ☐ Pending investigation 6 ☐ Could not be determined

Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

1 Inpatient

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

TOWSON, MARYLAND 21204

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number D37254

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOON POH LIM, M. D. 7601 OSLER DRIVE

32. Registrar's Signature 31. Date filed (Month, Day, Year) JAN 1 2 2009

Registrar

State

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760, <

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	-	For State Registrar	State of Ma	zi y iai i	_	rtificate of			leg. No. 200	00404
		Decedent's Name (First, Middle, La	ast)					2. Date of Dea Month		3. Time of Death
Physicia /Medica		Cleopatra,	Sirios	igar	nos			01	10 20	9 1130 1
Examine	er	4a. Facility Name (If not institution, gi		7		4b. City, Town, o	r Location of Death	МΙ	4c. County of De	ath ,
Funeral		5. Social Security Number 6.	Sex 7. Age	e (In vrs. I	ast birthday	Leon	If Under 24 Hrs.	8. Date of Birth	3+ 1 9. B	irthplace State or Foreign
Funeral Director			1□M 2♥F 79		Yrs.	Months Days	Hours Min.	8. Date of Birth Month, Pay 10/18/192	29 ^{year)}	aryland
nd •	-	Usual Residence of Decedent 10a, State 10b, County		10c City	v. Town or L	ocation				10d. Inside City Limits
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r 28a-	irec	10e. Street and Number	3	010		10f. Zip Code			10g. Citizen of What C	Country?
rs after death with the Marylan I", or items 23a or 28a-f show varning regist be notified at	Funeral Director	24736 Long Road				20624			U.S.A.	
items	nue	11. Marital Status	12. Was Decedent B Armed Forces?		S. 13.	Was Decedent of H If Yes, specify Cuba	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian, ite, etc.
irs aft	þ	1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	1 □Yes 2 📉 N If Yes, Give Year or Dates:	NO		1 ☐ Yes 2 💢 No	Specify:		Specify:	White
should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gi	ducation and completed)		16a. Dece	edent's Usual Occup	nation during most of work	ina	16b. Kind of Busines	s/industry
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2 shou and N is mai		19a. Informant's Name/Relationship							r, City or Town, State	Zip Code)
1 and 1 Health em 27		Estelle S. Raley, Da	aughter	Jook B			Clements, M	1D 20624 Date	20c. Location - City of	r Town State
permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exertione.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 [osition (Name of matory or other place	i .			
mit. P partme nortan injury	ł	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		uree		odox Cemeter 2. Name and Addre	ry 01/14/ ess of Facility Leo		Baltimore, M uck. Inc.	arytanu
permit. Depart Import any inj		Olgandia	Blan				d Road, Balt			
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eath certific attending p for use as	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			□ Ectopic pregnanc	24		23d. Date of d	
ne deat the att hed for	Physician/Medi	in the past 12 mønths? 1 □Yes 2 ☑No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown			Other (specify)			Month	Day Year
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pital o		29a. Certifier 1 ☐ Certifying F	Physician: To the best of	of my kno	wiedge dea	th occurred at the ti	ime date and place	and due to the	rause(s) and manner	as stated
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical Exa	aminer: On the basis of and manner sta	f examina	tion and/or i	nvestigation, in my	opinion, death occur	red at the time,	date and place, and di	ue to the cause(s)
To th within To th	Me	29b. Signature and title of certifien	1.11		2	29c. Licens			29d. Date signed (Mor	
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25		30. Name and address of person who MEHRDAD A KHLA		eath (Item	1 23a) (Type	Sotal d	lean of der	m MD	20650	
Stat	e	31. Date filed (Month, Day, Year)	32. Registra	ar's Signa	turd	1	V			
Registra	ar	JAN 1 2 2009	Clevera	13.17	Carlo Carlo					

1 - For State Registrar

			1. Decedent's Name	e (First, Middle, La	nst)								2. Date of Dea			3. Time of De	ath
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	Examin		4a. Facility Name (I			nber)			4b. City,	Town, or	Location			4c. County of Death			
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	Funeral		5. Social Security N		Sex 1 □ M 2 💢 F	7. Age (I	n yrs. last birt		If Under Months	1 Year Days	If Under Hours	r 24 Hrs. Min.	8. Date of Birt (Month, Da	y, Year)	9. Bir	thplace (State or Fountry)	oreigi
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j	0 0 0	Physic	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4 ☐ Pregn 9 ☐ Unkno		ne of death	5 □	Other (sp	ecity)							
7.	ding Physician: The law requires that the d. h. After this certificate has been signed by the funeral director, page 2 should be detached	무	Part II. Other signif	licant conditions	contributing to de	ath but no	ot resulting in	the und	derlying ca	ause give	n in Part	l.	23e. Did to	obacco u	se contribute to	the cause of deat	th?
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<u> </u>	Atte	ific	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place	of Injury	- At home, far Specify)	m, stree	et, factory	office		2	28f. Location (S City or Tou	Street and	d Number or Ru	ırai Route Number	r,
5	tal or s afte al Dir ed in	Certification:	, Ettomoide		Dallall	19, 010. (0	speciny)						City of You	m, State)	,		
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director, After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.		29a. Certifier (Check only	1 ☐ Certifying Pl 2 ☐ Medical Exa	hysiclan: To the	best of m	ny knowledge	, death	occurred	at the tim	ne, date a	ind place, a	and due to the	cause(s)	and manner as	s stated.	
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	5		141	holly	pur	7			1	16	s 20	4		MI	UMY	8, 2009	
	10		30. Name and addr	ess of person who	completed days	e of death	(Item 23a) (Type, P	rint)	Po-	(+	Pr.	lta n	21	2120	8	
	1	10	30. Name and addr	th. Day Year	(30 B	egistrar's	Signature	Y - C	ريها تو	Jus	ا /د	,,,,,	-10				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Tanuary Sauer 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death Baltimore 4 Baltimore Sinai Hospital N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9-24-1913 5. Social Security Number 7. Age (In yrs, last birthday) 6. Sex Birthplace (State or Foreign Country) Days Hours 1 □ M 2 □ F 95 Tennessee 410-48-3657 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ∐Yes 2v ☐ No Memphis Shelby 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe United States 38120 256 Colegrove Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21⁄2 No Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shimonovetz Rebecca Evensky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5818 Narcissus Avenue Baltimore, MD 21215 Marc Sauer-Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 💆 Removal from State 1-11-2009 Beit Shemesh, Israel 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sol Levinson & Bros. Inc. 21. Signature of Funeral Service Licensee 8900 Reisterstown Road Baltimore, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dar Preumon disease or condition resulting in death) Due to (or as a consequence of): Heart failure Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a. State

Director TN

Funeral

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Completed

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Examiner

Abe

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

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item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanciner must be notified at

permit. Pages
Department of
Important: If It
any injury or c

Physician

/Medical

by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	23d. Date of delivery Month Day Year		
ed by Pi	Part II. Other significant conditions Bronchi	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Únknown		
Completed			24a. Was an autopsy performed? 1 □ Yes 2 □ No 1 □ Yes 2 □ No		
Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
0	1 Yes 2 No	Hospital: 1 Hopatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	ne 5 Residence 6 Other (Specify)		
ation: I	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Day, Year) Injury Work?	28d. Describe how injury occurred		
Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)		

29c. License number

D65718

W. Belvedere Ave,

29d. Date signed (Month, Day, Year)

2009

12 State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ,2401 MD 32 Registrar's Signature 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

JAN 12 2009

within 24 hours a

To the Funeral C

completely filled

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 00407 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle,Last) Physician/ молth January 1, 2009 1250 hrs cal Examiner Jennifer Thomas 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3725 Ellerslie Avenue Baltimore 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs **Funeral** Foreign Hours Months Days Director Country) 6/18/1949 M 59 Md. 2X XF 217-52-5873 Usual Residence of Decedent È 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No or items 23a or 28a-f show must be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene, unt. If item 27 is marked other than "natural", or items 33s no 38s. February. Md. N/A Baltimore Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? West Cross 21230 Street USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. Armed Forces? 1 X Never Married 2 Married Yes 2X No If Yes, Give Year Yes 2X No specify: Widowed Divorced Specify: Black ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) l other than " the Medical 1 MD 21215-0036 Employee Glass Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer Thomas Gladys Thomas 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nicole Harvey 719West Cherry Glossom Way, Baltimore, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date Baltimore, 1 X Burial 2 crematory or other place) Cremation 3 Removal from State Department o /8/2009 Western Cemetery Baltimore. Donation 5 Other Spe 10 e of Funeral S ²² Name and Address of Facility
Estep Brothers Funeral Service
1300 Eutaw Place, Baltimore, e censee Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical g physician a UNPENDED AMENDED Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Month Day Year signed by the attending be detached for use as t Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✓ Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ξ 1 Yes 2 No 3 Probably 4 V Unknown Diabetes mellitus Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 ✓ No Yes No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: Other₄ DOA Nursing Home 5 Residence 6 ✔ Other: Scene After this Inpatient 2 ER/Outpatient 2 1 Yes 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: 1 V Natural Pending Yes 2 No death 2 Accident Investigation in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2 To the I 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME January 4, 2009 O.C.M.E. JR and address of person who completed cause of death whem 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

welled.

arken

09-00220 Mark Anthony Unkart

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physici		t State of Maryland / L I-For State Registrar 1. Decedent's Name (First, Middle,Last)	Certificate of Death		Reg. No. 2	0 0 9 0 0 1 3. Time of Death
Physici cal Exami		Mark A. Unkart			Month Day Year January 8, 2009	0850 hrs
eq.		4a. Facility Name (if not institution, give street and number)		own, or Location of Death	4c. County of D	eath .
		Carroll Hospital Center	Westn		Carroll	2.1.1.2.40
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Unde Months Yrs.		8. Date of Birth (MM/DD/YYYY) 9 For Aug 27, 1963	. Birthplace (State or preign Country) MD
		Usual Residence of Decedent	Oc. City, Town or Location			10d. Inside City Limits
w any						1 Yes 2 X No
eath with the Maryland items 23a or 28a-f show ust be notified at once.	to	PA Adams 10e Street and Number	Littles		10g. Citizen of What	Country?
with the Maryfand 18 23a or 28a-f sho 20 notified at once	Director		101. Zip			,
th the 23a o notifi		21 Colonial Court 11 Marital Status 12. Was Decedent E	vot in LLC 12 Mac Docode	17340 nt of Hispanic Origin? (Spe	USA pointy Yes of No- 14 Race - A	merican Indian, Black,
death wi or items must be	Funeral	1 Never Married 2 w Married Armed Forces?	If Yes, specify	Cuban, Mexican, Puerto R	Rican, etc.) White, e	
÷	F	1 Yes 2 x 3 Widowed 4 Divorced If Yes, Give Year	No 1 Yes 2	X No specify:	Specify:	White
rs aft ural"	by	15. Decedent's Education (Specify only highest grade compl	leted) 16a. Decedent's Usual (Occupation (Give kind of wo	ork done 16b. Kind of Busin	ess/Industry
ted within 72 hours Hygiene. other than "natur the Medical Exam	Completed	Elementary/Secondary (0-12) College (1-4 or 5+	during most of wor	king life. DO NOT use retire	ed)	
ould be filed within 7 Mental Hygiene. marked other than ic event, the Medica	힐	12	Shop	Foreman	Bare Ti	cuck Center
ed wi lygier other he M	ပြွ	17. Father's Name (First, Middle, Last)		18.Mother's Name ((First, Middle, Maiden Surname)	
be fill ntal F rked ent, t	Be	August S. Unkart			Virginia Haines	
d 2 should Ith and Me n 27 is ma	ြို	19a. Informant's Name/Relationship (Type, Print)			ural Route Number, City or Town,	
d 2 sh Ith an n 27 i		Judy D. Unkart Wife			ttlestown, PA 1	L 7340
l and l'Heal fiten er tra		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State	20b. Place of Disposition (Nan crematory or other place)	ie of cemetery,	Date 200. Location - C	ity or rown, state
permit Pages I are Department of Her Important: If ite injury or other tr		4 Donation 5 Other Specify:	Lake View Mem	Park 1/1;	3/09 Sykesvi	ille, MD
permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygeria. I hoportant: If item 27 is marked other than "natural", important: If item 27 is marked other than "natural", injury or other tranmatic event, the Medical Examiner.		21. Signature of Funeral Service Licensee			824 Reisterstown	
ii II De		Sans & line	ELINE	FUNERAL HOME	Reisterstown,	MD 21136
nysician		2 a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	ne death. Do not enter the mode of	of dying, such as cardiac or	respiratory arrest, shock, or heart	Detween Onset and
Medical xamine			rtery thrombosi	S		Death
cecufed and - transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consect due to (or as a co	quence of):			
6 5 5	ica	X UNPENDED AMENDED PI	line a-b, 27 pe	r ME G887 1/	16/09 TT	
To the Hospital or Attending Physician: The law requires that the death certificate be exwittin 24 hours after death. To the funeral birector: After this certificate has been signed by the attending physician. To the funeral birector and director may be should be detached for use as the burial.	sician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcom 1 Live birth 4 Pregnant at ti	2 Fetal death	3 Ectopic pregnal	ncy 23d. Date of d	elivery Day Year
eath c atter	sic	1 Yes 2 No 9 Unknown g Unknown	ime of death 5 Other (Spe	511y)		
t the d by the		Part II. Other significant conditions contributing to death	but not resulting in the underlying	cause given in Part I.	23e. Did tobacco use contrib	ute to the cause of death?
res that the signed by be detach					1 Yes 2 No 3	Probably 4 Unknown
w requires been so	Completed		-			ere autopsy findings available or to completion of cause of
law r has b					performed? de	ath?
hysician: The this certificate	ြ			26.Place of Death (Check of		Yes 2 No
certi	a	25. Was case referred to medical		I Othor:	g Home 5 Residence 6	Other:
Physical distribution of the second of the s	2	1 V Yes 2 No		28c. Injury at Work?	28d. Describe how injury occurre	
ding Pl	5	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injur (Month, Day, Ye	ar)	1 Yes 2 No		
deat deat	 	2 Accident Investigation	ury - At home, farm, street, factor	v. office building, etc.	28f. Location (Street and Number	or Rural Route Number, City
ospital or / hours after meral Dire	Certification:	Suicide Could not be determined (Specify)	ary 7 (c) (c) (c) (c) (c) (c) (c) (c) (c) (c)	J	or Town, State)	
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in twy the funeral director page.	Cal Ce	29a. Certifier 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of exam	knowledge, death occurred at the	e time, date and place, and y opinion, death occurred a	due to the cause(s) and manner a	as stated. e to the cause(s)
To t To t	Medical	and manner stated. 29b. Somature and title of certifier		c. License number		d (Month, Day, Year)
	-	1/10.10.10		O.C.M.E.	January 9, 2	2009
		Varustell)	noth (Itam 225)			
N		30. Name and address of person who completed cause of de Laron Locke MD. Assistant Medical Exa		t, Baltimore, MD 212	201	
		Laton Looke MD. Addistant Modical Like				
V	Stat	31. Date filed (Month, Day, Year) JAN 1 2 2009	's Signatule			

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- For State Certificate Registrar		eg. No. 2009 0040
Physi Iedical Exa		1 1. Decedent's Name (First, Middle,Last) er Mark Patrick Watkins	2. Date of Deal Month January 9	Day Year
		4a. Facility Name (if not institution, give street and number) 106 Springside Drive	4b. City, Town, or Location of Death Lutherville Timonium	4c. County of Death Baltimore County
Funer Direct		5. Social Security Number 220-04-3169 6. Sex 12 Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. 8. Date of Bir Yrs. Months Days Hours Min DeC • 16	1
and show any	20	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore County Timonius	m	10d. Inside City Limits 1 Yes 2 No
death with the Maryland or items 23a or 28a-f show	notified at once	10e. Street and Number 2 Belinullet Court Unit 201	10f. Zip Code 21093	og. Citizen of What Country? United States
death wi	Finar	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 No specify:	white, etc. Specify: White
215-0036 Effect within 72 hours after nital Hygiene. rked other than "natural", of	ical Exan	Elementary/Secondary (0-12) 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) 12 Huma:	dent's Usual Occupation (Give kind of work done g most of working life. DO NOT usa retired) n Resource Manager	Curry Printing
21215-0036 and be filed within 7 Mental Hygiene.	event, the Medical	Joseph Thomas Watkins	18.Mother's Name (First, Middle, Patricia Victo	ria Michalek
MD 2 nd 2 should alth and M	raumatic e	Patricia & Joseph Watkins (Parents)	illing Address (Street and Number or Rural Route Num 106 Springside Drive 5	riber, City or Town, State, Zip Code) Fimonium, Maryland21093 120c. Location - City or Town, State
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Montal Hygiene. Important: If item 27 is marked other th	ry or other to	1 Burial 2 X Cremation 3 Removal from State Evans F	uneral Chapel Jan.14, 2009	Forest Hill, Maryland
Physicia	_	23a / at 1. Inter vie disease, or complications that caused the death. Do not ent		rest, shock, or heart Approximate Interval
/Medic xamin	al	fature List poly one cause on eath line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		Between Onset and Death
	à	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		
The P	transit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
0, e be executed	burial - tr	X UNPENDED AMENDED 23a & 27 per	ME g888 2/18/09 TT	
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5 9 Unknown contributing to death but not resulting in the past 1.	Fetal death 3 Ectopic pregnancy Other (Specify)	23d. Date of delivery Month Day Year
P.O. Bees that the degree by the	deta	p		obacco use contribute to the cause of death?
Records The law requented that the been	2 should	Completed	1 ✓ Yes	psy prior to completion of cause of death?
ital Redicion: The scertificate	ector	(b) 25. Was case referred to medical examiner? Hospital: 1 Inpution: 3 EB/Output	26.Place of Death (Check only one) Other Nursing Home 5	Residence 6 ✔ Other: Scene
	E .	27 Manner of Death 28a Date of Injury 28b Time		how injury occurred
IVISI or Att after de Direct	filled in by the	The state of the s	street, factory, office building, etc. 28f. Location (or Town,	(Street and Number or Rural Route Number, City State)
Div To the Hospital or within 24 hours afte To the Funeral Di		Zea. Certified 1 Certifying Physician: To the best of my knowledge, death or (Check only one) 2 Medical Examiner: On the basis of examination and/or invest	ccurred at the time, date and place, and due to the cau tigation, in my opinion, death occurred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
	_ ≥	and manner stated. 29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) January 10, 2009
(2)		30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 F	Penn Street, Baltimore, MD 21201	
/		Zapiulian Ali, W.D. Assistant Wedical Examine 1117	orni oucoc, bandinoro, MD 21201	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00410 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Ralph S. Wainwright 10:30 PM anuary 2009 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Burni Medic Cente Washington Anne Social Security Number If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Aug 6, 1935 Birthplace (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) **Funeral** 1**☑** M 2□ F Days Hours Director 73 220-32-7814 Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "naturel", or Items 23a or 28a-f sho traumetic event, the Medical Examinar must be notified at Yes 2 □ No Director Glen Burnie Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21061 404 Marley Station Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 1957 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Bace - American Indian. permit. Pages 1 and 2 sho lid be filed within 72 nours after to Department of Health and Tental Hygiene.
Important: If item 27 is marked other than "naturel", or Iten eny Injury or other traumatic event, the Medical Evernment once. Black, White, etc. 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1957 1 ☐ Yes 2 X No Specify: Black ⋛ Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates 1962 Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) NSA Elementary/Secondary (0-12) College (1-4or 5+) Communications Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lena Wainwright Frank Wainwright 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 Marley Station Road Glen Burnie, Maryland 21061 Earnestine Wainwright 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/09/09 Owings Mills, Md. Garrison Forest Veterans Cemetery 5 ☐ Other (Specify) 4 Donation Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23.1 art1. Enter the Jisease, or complications that caused the Jeath. D Hot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Filture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Precumonia BACTENIAL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner METASIMLIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (of as a consequence of). attending physician and for use es the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 Other (specify) this certificate has been signed by the all director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 npatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JANUARY 1,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balkmore Washington Medical Center Franci MD 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			Please							-	Are Legible		
		For State Registrar		State of Ma	arylan		irtment <i>tificate</i>			,	giene _{Reg. No.} 200	19 001.11	
Physicia	n	1. Decedent's Name (Fire	st, Middle, Las	,						2. Date of De Month	ath Day Ve	3. Time of Death	
/Medic	al	4a. Facility Name (If not	institution aive		geline	Wiml		OWEN OF	Location of Death		Jan 2, 2009 4c. County of D	11:55 а м	
Examin	er	ra. raemy rame (n nor		hwest Hospital	Hospid	ce	4D. City, 10	JWII, OI		lallstown	4c. County of D	Baltimore	
Funeral Director		5. Social Security Number	1	ex 7. Ag □M 2 □ x F		ast birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hrs. Hours Min.	(Month, Da	Birth 9. Birthplace (State or Foreign Country)		
		219-16-97 Usual Residence of Dece	edent			52				Feb	2, 1916	Virginia	
//arylar f show	Į.	10a. State 10b.	. County	N/A	10c. City	y, Town or Loc	cation	E	Baltimore		10d. Inside City Limits 1 ☐ Yes 2 ☐ No		
th the P or 28a-	Director	10e. Street and Number			<u> </u>		10f. Zip C				10g. Citizen of What Country?		
sath wi		456 Roundvi	iew Road	40 Mar Dooders	Francia III	0 140.14	Na - Dans da	-A -6 11:	21225			U.S.A.	
after de	Funeral	11. Marital Status 1 ☐ Never Married	2 ☐ M arried	12. Was Decedent Armed Forces?					spanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)		merican Indian, hite, etc.	
hours a	ed by	3 Widowed 4		If Yes, Give Yeer or Dates:			Yes 2		Specify:		Specify:	Black	
hin 72 9. an "nat	Completed	(Specify or Elementary/Secondary	Decedent's Ed	ucation de completed) College (1-4or 5	54)	(Give I	lent's Usual kind of work DO NOT use	done di	uring most of work	ing	16b. Kind of Busine	,	
led with Hygiene her the	Con	12		- College (1 40) a	, , ,				N Nurse	(F)		ay Nursing Home	
ld be fi lental H ked ot ic ever	To Be	17. Father's Name (First,		er Clark					18. Mother's Nam		Maiden Surname) Effie L. Clark		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Important: If the ZT Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It is Medical Examinar for rediffed at once.	-	19a. Informant's Name/F	Relationship (7	Type. Print)							er, City or Town, Stat	e, Zip Code)	
1 and Health em 27 ther tr		Jocelyn Wim 20a. Method of Disposition			20h P	lace of Dispos			w Road Balti	more, Man	yland 21225 20c. Location - City	or Town State	
Pages nent of nt: If it iry or o		1 Duriet 2 Cre 4 Donation 5 D	emation 3 🗆	Removal from State	C	emetery, crem	natory or other	e <i>r plac</i> e	9)	01/08/09		wne, Maryland	
permit. Departm Importa any Inju		21. Signature of Funeral		/	1		. Name and	Addres	s of Facility	aral Cando	-		
20 = 6 0	\dashv	23a. Part 1. Enter the dis	sease or com	lications that caused	the death	A pot ente	11	300 E	Brothers Fun Lutaw Place I	Baltimore_I	Md 21217	Approximate	
Physician		shock, or heart fail Immediate Cause (Final disease or condition	ure. List only	one cause on each lin	ne.				entifi.	or respiratory a	11631,	Approximate Interval Between Onset and Death	
/ /Medical Examiner		resulting in death)		Due to (or as									
	Je.	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	ns, ate	b Due to (or as	a consequ	uence of):							
be executed clan and ourial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	c									
bur licia		resulting in death) cast	ı	Due to (or as	a consequ	uence of):							
eath certificate be executed attending physiclan and for use as the burial-transit	Physician/Medical		_	d									
ath ce attendii for use	ian/	IF FEMALE: 23b. Was decedent preg in the past 12 month		23c. If yes, outcome 1 Live birth	2 Fetal	Ideath 3 🗆	Ectopic pre				23d. Date of Month	delivery Day Year	
the de	hysic	1 ☐ Yes 2 ☐ Vio 9 ☐ Unknown		4 ☐ Pregnant a 9 ☐ Unknow <i>n</i>	t time of d	eath 5∟	Other (spec	cify)					
es t igne be d	þ	Part II. Other significant	conditions of	ontributing to death b	ut not resu	ulting in the un	nderlying cau	ise give	n in Part I.	23e. Did t	obacco use contribut	e to the cause of death?	
requil	eted	- 1/4										Probably 4 □ ₩nknown	
The law te has age 2 :	Completed						_				rmed? prior death		
clan: " ertifica ector, p	Be C	25. Was case referred to examiner?	medical						26. Place of Deat		nne)	1 2	
Physic rthis caraftire	၉	1 Yes 2 No 27. Manner of Death		28a. Date of Inju	iry	ER/Outpatient					dence 6 Other (5	pecify)	
ath. rr: Afte	atior	2 Accident	Pending investigation	(Month, Da	y, Year)	Injury	м	injury Work: 1 □ Y	? ′es 2 □ No	Edd. Describe	iow injury occurred		
or Atter ufter de Directo	Certification:	3 Suicide 6 [4 Homicide	Could not be determined	28e. Place of Injubulding, etc.	ury - At ho c. <i>(Specif</i>)	me, farm, stre	eet, factory, o	office		28f. Location (; City or To	Street and Number or vn, State)	r Rural Route Number,	
spital nours a neral [29a. Certifier 1	Certifying Ph	ysician: To the best	of my kno	wledge, death	occurred at	t the tim	ne, date and place,	and due to the	cause(s) and manne	r as stated.	
the Ho hin 24 I the Fu npletel	Medical	one)	Medical Exam	niner: On the basis o and manner sta	of examina	tion and/or inv	vestigation, i	n my op	pinion, death occur	red at the time,	date and place, and	due to the cause(s)	
vit vit		29b. Signature and title of	1 CVC	110				Non	S7465		29d. Date signed (M	· 1 - 1 - C	
15		30. Name and address o	f person who	completed cause of d	leath (Item	1 23a) (Type, F	Print)		57465		415	12/04	
le		N.S. Rajuf 31. Date filed (Month, Da	OdKSQ, 1	10 25 N	ARIA!	St, Syl	te 201	0,1	keisersh	INO.	MD. S	1136	
Stat Registra		JAN	V 1 2 20	09 Deca	A /	B. Soa	aked				MD.Z		

09-00140 Tian Wang

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day January 5, 2009 2147 hrs **Medical Examiner** Tian Zin Wang 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Months Director 07/21/1957 219-35-6181 51 Country) China 1X M Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 28a-f show 1 Yes 2 XX No Columbia Maryland Howard notified at once. with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 6121 Silver Arrows Way 21045 China 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14 Race - American Indian Black 11. Marital Status 12. Was Decedent Ever in U.S. White, etc death 2 XX Married Armed Forces 1 Never Married 2XX No Yes 5 If Yes, Give Year after Divorced Yes 2 X No specify: Specify: Asian Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after
Department of Heakh and Mental Hygi within 72 hours after
Important: If item 27 is marked other than "natural",
injury or other traumatic event, the Medical Examiner. à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Restaurant Owner Food Industry 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dagi Wang Shui Xian Yang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ai Zhu Zheng (Wife) 6121 Silver Arrows Way Columbia, Maryland 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 XX Burial 2 Cremation 3 Removal from State 1-19-2009 Meadowridge Memorial Park Elkridge, Maryland Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 234. Part I, Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and Death failure. List only one cause on each line /Medical a Multiple Gunshot Wounds Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): that the death certificate be executed Physician/Medical UNPENDED attending physician or use as the burial -AMENDED Box 68760. IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o 2 م Yes 2 ✔ No 3 Probably 4 Unknown Completed Records, 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy The law certificate has performed? death? ✓ Yes 2 ~ Yes No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 26.Place of Death (Check only one) 25. Was case referred to medica Division of Vital Be examiner? Hospital: 1 🗸 Inpatient 2 Other 4 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 ✓ Yes 28a. Date of Injury 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot Jan 3, 2009 0000 hrs Natural 1 ✓ Yes 2 No Pending Director: d in by the f 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) 800 Blk. Webb Court , Baltimore , MD (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 6, 2009 O.C.M.E. 3C. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. Assistant Medical Examiner State 31. Date filed (Month, Day, Year) 32 Registrar's Signature arks Registrar ŋ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 3:46 PM James Januan 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hep Kin 5. Social Security Number If Under 1 Year If Under 24 Hrs Bayview Medica 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day Year) Aug 3, 1921 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours Min. 215-14-4586 87 Aug Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD 1 ☐ Yes XX No Director Baltimore Essex 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21221 USA 1813 Old Eastern Ave Unit 249 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 No Specify þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Intelligence Officer Airforce 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ages 1 and 2 should be file ent of Health and Mental H it: If Item 27 is marked oth y or other traumatic event Be Philip A. Wise, Sr. ပ္ Mary A. Gunning 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Fox / Nephew 703 E. Seminary Ave. Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or once. Garrison Forest Cem. 1/23/2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Majocardial disease or condition resulting in death) /Medical Due (or as a consequence of) Examiner Gastrointestine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence off The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Box 68760. physician use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a Ö 1 ☐ Yes 2 ☐ No 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an page 2 s has autopsy certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 Natural hours after death.

neral Director: Af

filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely (Check only one) and manner stated. within 2

State Registra

X

29b. Signature and title of certifier

31. Date filed (Month, Day,

30_Hame and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Degedent's Name (First, Middle, Last) 2. Date of Death Mont Physician NGELA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice of the Chesapeake Linthicum Anne Arundel . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, 6. Sex **Funeral** Months Days 1 □ M 2 ☑ F Hours Min. Director 67 Jan 25, 1941 Maryland 216-36-8542 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 2 should be filed within 72 noors.
1 and Mental Hygiene.
7 Is marked other than "natural", or items 23a or 28a-f show a marked other than "natural", or items 23a or 28a-f show a marked other than "natural", or items 23a or 28a-f show a marked of the Madical Examiner must be notified at 1 ☐ Yes 2 ▼ No Director Glen Burnie MD Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 6666 Roberts Court #69 21061 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 | No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 □Yes 2 🕅 No Specify: white Specify 3K Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Alexander Ramanauskas Louise Anna Borkoski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 si
Department of Health an
Important: If Item 27 Is i
any injury or other trau Angela E. Theiss/daughter 1032 7th Street Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Lice Ronald S 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician for use as the burial law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 Other (specify) signed by the a P.O. I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 ☐ Yes 2 No cate has been si page 2 should b 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn certificate 1 ☐ Yes 2 No 1 □Yes 2 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) OSPICE 2 No Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Naturu. 2 ☐ Accident Natural 5 Pending investigation after death.

I Director: Af din by the fur 1 □ Yes 2 🗆 Na 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled in the Filled in th Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only anner stated 29c. License number

D V 438

State Registrar

29b. Signature and title of certifie

lame and address of per

31. Date filed (Month

DHMH 17 Rev 1/2001

who completed cause of death (Item 23a) (Type, Print) DEFENSE HIGH WAY

Registrar's Signature

Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#23e, perPHYS. G887, 1720/09 WS
State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month JANUARY 11, LOUIS JOHN ALTHOFF 2009 10:20 AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 1419 ROWE DRIVE GLEN BURNIE ANNE ARUNDEL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Y MAR 20, Birthplace (State or Foreign Country)
 MARYLAND **Funeral** . Year) 1950 1፟∭ M 2□ F Months Days Hours Min. 58 218-52-1789 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, its shodies Examinat must be notified at optice. 10d. Inside City Limits Director MARYLAND ANNE ARUNDEL 1 □Yes 2 No GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1419 ROWE DRIVE 21061 Funeral UNITED STATES 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: \$ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MACHINE OPERATOR MANUFACTURING 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be innent of Health and Mental LOUIS FRANCIS ALTHOFF GRACE VIOLA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANNE L. ALTHOFF / WIFE 1419 ROWE DRIVE, GLEN BURNIE, MARYLAND 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State JAN. 1 Burial 2 □ Cremation 3 □ Removal from State ALL SAINTS CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 2009 WILMINGTON, DELAWARE 21. Signat e progral Ser Name and Address of Facility RKLEY-RUDDICK 1 CRAIN HWY., FUNERAL HOME, P.A. S.E., GLEN BÜRNIE, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Head - neck cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner spread cance Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of): requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the IF FEMALE: for use yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) ed by the detached f Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 Ves No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 24a. Was an page 2 : autopsy performed? certificate the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ₹ Residence 6 ☐ Other (Specify) 1∐Yes 2∭XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending the Funeral Director; Aff 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29b. Signature and title of certifier ٥ 29c. License number 29d. Date signed (Month, Day, Year) D54413 JANUARY 12, 2009 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YOUNG JOO LEE, M.D., 3001 HANOVER STREET, BALTIMORE, MARYLAND 21225

State Registrar

DHMH 17 Rev 1/2001

JAN 1-3 2003

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** LANUAR-James G. Breedlove /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimor If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 □ F Months Days Hours Min. 88 Director 11/07/1920 427-26-3664 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evantinar must be notified at 1 Nes 2 No Director MD Columbia Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2 should be filed within 72 hours after death with to and Mental Hygiene.

Is marked other than "natural", or items 23a or? Funeral 21044 6336 Cedar Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1; Yes 2 ☐ No 14. Race - American Indian 11. Maritai Status Black, White, etc. 1 Yes 2 ☐ N If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 22No Specify ρ Specify: 3₺ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Ceramics Elementary/Secondary (0-12) College (1-4or 5+) Scientific Researcher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic esones. Mary Elizabeth Jeffcoat ပ Enoch Marvin Breedlove 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally B. Byrne/Daughter 11714 Wayneridge Ct. Fulton MD 20759 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State Jan 13 4 ☐ Donation 5 ☐ Other (Specify) 2009 Beltsville, Maryland Chesapeake Crematory Inc. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1443 Cremation and Funeral Alternatives Maruland 21286 8717 Green Pastures Drive Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause un each line. pproximate Interval Between Onset and Death Immediate Cause (Final **Physician** mon ths disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe this certificate 1 □Yes 2 No 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1. ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be execute Records, P.O. Box 68760, **Division of Vital**

3altimore, Maryland 21215-0036

filled in by the funeral after death Director: 24 hours a

within 2 To the I

completely

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A A LILEO REVELE 900 Caton Ave. Baltimore, 31. Date filed (Month, Day, Year) 32. Registrar's Signature 3 2009

and manner stated.

determined

4 Homicide

29b. Signature and title of certifier

29a, Certifier

Ossifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State of Maryland / Department of Health and Mental Hygiene 1 - For Redistrar Certificate of Death Reg. No. 2 0 0 9 0 0 4 1 7
	Physicia	an	1. Decedent's Name (First, Middle Last) 2. Date of Death Month Day Year 2. Date of Death
1	/Medic Examin Funeral	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death And Deat
	Director t show	ior	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 10b. County 10c. City, Town or Location 10d. Inside City Limits
	with the N 3a or 28a- 1 be notifi	Funeral Director	10e, Street and Number 10f, Zip Code 10g, Citizen of What Country? 12909 Fox Bow Rd # 402 207744 115 A
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merfall Hylgiene. Important: I fitem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Nodical Exactions any injury or other traumatic event, I'm Nodical Exactions and injury or other traumatic event, I'm Nodical Exactions and injury or other traumatic event, I'm Nodical Exactions and I'm Nodical Exactions are injuried.	۵	11. Marital Status 1 Never Married Widowed 4 Divorced 1 Divorced 1 Ves Color Dates: 1 Ves Decedent Ever in U.S. Armed Forces? 1 Ves Specify Cuban, Mexican, Puerto Rican, etc.) 1 Ves Specify: S
21215-0036	filed within 72 ho Hygiene. other than "natur ent, II.« Wolforl	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4
Maryland	2 should be file o and Mental Hy is marked oth raumatic event	To Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19. Informant's Name/Relationship (Type. Print) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, tate, Zip Code)
ď	Pages 1 and 2 nent of Health ant: If item 27 i ury or other tre		Karen T Bracks - Wite 12908 Fox Bow Fd #402, Upper Manboro, MD 20a. Method of Disposition 12 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 120b. Place of Disposition (Name of cemetery, crematory or of their place) 1312009 CrownSville, MD
Balti	permit. Departri Importa any inju		21. Signator of Funeral Service Licensee 22. Name and Address of Facility Howell Funeral Horse 10220 Guilford Rd, Jessup, MD 20794
	Physician / /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Let ue to (or as a conse pence of): Due to or as e consequence of): Due to or as e consequence of): List only one cause or respiratory arrest, shock, or heart failure. List only one cause on each line. Nowthat initiated events Due to or as e consequence of): List only one cause or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of): List only one cause or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of): List only one cause or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of): List only one cause or respiratory arrest, shock, or heart failure. List only one cause or each line. Due to (or as a consequence of): List only one cause or respiratory arrest, shock or respiratory ar
Box 68760,	res that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit	Physician/Medical Ex	Due to (or as a consequence of): d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No Nonth Day Year Oue to (or as a consequence of): d. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year Oue to (or as a consequence of): 1 July Ju
ords, P.O.	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. within 24 hours after death. to the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as t	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown
ital Rec	ician: The law r certificate has be rector, page 2 sh	Be Completed	24a. Was an autopsy findings available prior to completion of cause of death? 25. Was case referred to medical 26. Place of Death (Check only one)
of V	Physic r this ce ral direc		examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Autursing Home 5 Residence 6 Other (Specify)
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: To	Month, Day, Year Injury Work? 1 Yes 2 No Squicide A Homicide
	he Hospit in 24 hour he Funera pletely fille	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To with	Σ	29b. Signature and fittle of certifier 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)
	4		Raman Tuli - 10810 Darnestown Rd
	Sta Registr		Raman Tilli - 10810 Darnestown Rd 31. Date filed (Month, Day, Year) JAN 13 2009 Registrar's Signature J. Sauce

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene 2 0 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2009 6:30PM M Sr January Garnett Brubaker /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death **Examiner** Charlestown Extended Care Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. r) Country) 14 1913 1 → M 2 F 95 216-05-4505 November Director Usual Residence of Decedent the Maryland 10d Inside City Limits 10a. State 10b County 10c City Town or Location Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Modical Examination must be notified at once. 28a-f shov Catonsville Maryland Baltimore 1 ∐Yes 2 ⊠ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No white Specify: Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Customer Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Brubaker Grandville M Tda Μ. Stoner ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edwin H Brubaker 814 East Fort Ave. Baltimore MD 21230 son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. Jan. 9,2009 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se vice Licensee 22. Name and Address of Facility Stallings Funeral Home P.A. 3111 Mountain Road Pasadena MD 21122 23a. Part 1. Enter the disease, or complice tons that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only only couse on sech line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Du Vo (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jacas of Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2.☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending death. 1 ☐Yes 2 ☐ No investigation 2 Accident 24 hours after deatl Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 6020191 HVL1 Wil aidin Chiru 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 140 alle 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Sarnett

	1	For State Registrar	State of Ma	Cei	rtificate of L			g. No.		
		. Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Death	
Physicia		Dororhy	V	. Br	azell		January	9, 2009	1:12 A	
/Medica Examine		a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Deat	n	
_xa		Anne Arundel Med	lical Cent	er	Annapo	lis		Anne Arı		
Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birtl	nplace (State or Fore untry)	
Director		419-26-4416	☐M 21公F	83 Yrs.	Months Bays		Feb. 15,		labama	
	-	Usual Residence of Decedent		10c. City, Town or Lo	agtion .				10d. Inside City Lim	
how		10a. State 10b. County	2 2	•					1 ☐ Yes 2 ☐X	
perfitting a state of state of the winds and other than the perfitting the state of	용	Md. Anne Ar	undel	G1	en Burnie	··········				
or 28	e l	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?	
238	<u>a</u>	7992 Perthshire				21061		USA		
ems ELT	by Funeral Director	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White		
a a	F	1 Never Married 2 Married	1 ☐ Yes 2 ☐ਐ If Yes, Give	lo	1 ☐ Yes 2 ☐ No	Specify:		Specify: \[White	
- E -	d b	3. Widowed 4 □ Divorced	Year or Dates:				- 1	Ob Mind of Business	la di sata i	
dica	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Deca (Give	dent's Usual Occup	ation during most of workir f)	ng l	6b. Kind of Business/	industry	
than "	Id I	Elementary/Secondary (0-12)	College (1-4or 5	+)		,,		*** 1 1	1	
ygier ner ti	ខិ	12	2	l Ho	memaker	18. Mother's Name	(First Middle M	Househol	<u>a</u>	
d oth	Be	17. Father's Name (First, Middle, Last)		_ ,					77 . 1	
Men arke etic	P.	Charles	<u>W.</u>	Lamb		Elizab		A.	Hughes	
and eum		19a. Informant's Name/Relationship (7						City or Town, State, 2		
n 27 n 27 er tr	η.	William Brazell	(Son)					nie, Md. 2		
r of He		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Disp cemetery, cre	osition (Name or matory or other plac	-,	15			
nent ant: I	- 1	' 4 Donation 5 Other (Specify		Greenlaw	n Cemeter	ry 20	009	Roswell, G	a.	
Departr Imports any inju once.		21. Signature of Funeral Service Licer	see /	2	2. Name and Addre	ss of Facility Sta	llings H	Funeral Ho	me PA	
8 3 2 6		1 AM DE	8					Md. 2112	2	
		23a. Part1. Enter the disease, or complete or heart failure. List only	one cause of each li	the death. Do not en	ter the mode of dyir	ng, such as cardiac o	r respiratory arre	est,	Approximate Interval Between	
nysician -		Immediate Cause (Final								
Medical		disease or condition resulting in death)	d	a consequence of):	W.T. 1801	140			angs	
xaminer			. Aprt	c stemos	5.55				42W-5	
	ē	Sequentially list conditions, if any, leading to immediate	D	a consequence of):						
ansit	mir	Cause (Disease or injury that initiated events	Hyne	rkalemia					hours	
physician and the burial-transit	Examiner	resulting in death) Last	Due to (or as	a consequence of):	0 1				4	
physician the buria	dical		a Hute	rand	failure	と			days	
phys	edic									
e attending of for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of de	livery	
atte for t	ciar	in the past 12 months? 1 □ Yes 2 ☑ No	1∐Live birth 4∐Pregnant at		□Ectopic pregnanc □ Other (specify) _	у		Month	Day Yea	
0 2	ysi	9 Unknown	9□ Unknown							
ed by deta	/Ph	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the	underlying cause giv	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death	
sign d be	d by	Atrial fibri	Ilution				1 □ Ye	s 2 No 3 P	robably 4 □Unk	
peen	Completed						24a. Was a	n 24b. Were a	utopsy findings ava	
	ldu	Trombougto	spania				autops perform	y prior to death?	utopsy findings ava completion of caus	
has e 2		Pulmonary h	yperten	5,017					2 ☑ No	
	o	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Death				
	00	1 ☐ Yes 2 ☑ No	1 Inpatie	- 1	ant 3 DOA	4 Nutsing no		once 6 □Other (Special own injury occurred	ecify)	
	ပ္		28a. Date of Inju (Month, Da	y Year) Injury	Wo	rk?]Yes 2□No	200. 2000100 110	W Injury Coodings		
After this certifica	ပ္	27. Manur of Death 1 atural 5 Pending				in the second	28f Location /St	reet and Number or R	uml Route Number	
After this certifice funeral director,	ပ္	1atural 5 Pending investigation	n							
After this certifice funeral director,	ပ္	1 atural 5 Pending	n 28e. Place of In	jury - At home, farm, s cc. (Specify)	street, factory, office		City or Town	, 01010)	Brut / toble / tb///be/	
n. After this certifice funeral director, j	0	1 atural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not b determined	e 28e. Place of In building, et	tc. (Specify)	275/1923 E					
After this certifica	Certification; To	1	28e. Place of Inbuilding, et	of my knowledge dea	ath occurred at the fi	me, date and place,	and due to the ca	ause(s) and manner a	s stated.	
rospite or Attentining Frigorican. Fur hours after death. Stely filled in by the funeral director, it	Certification; To	1	28e. Place of Inbuilding, et	of my knowledge, dealer examination and/or	ath occurred at the ti investigation, in my	opinion, death occur	and due to the cared at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)	
for Attending Projection. The far after death. Director: After this certificate has In by the funeral director, page 2	ပ္	1	28e. Place of Inbuilding, el	of my knowledge, dealer examination and/or	ath occurred at the ti investigation, in my	me, date and place, opinion, death occurr se number	and due to the cared at the time, d	ause(s) and manner a	s stated. e to the cause(s)	
nospine or Areativing Frigoroge. 24 hours after death. Funerel Director: After this certifics stely filled in by the funeral director, i	Certification; To	1	28e. Place of Inbuilding, el	of my knowledge, dealer examination and/or	ath occurred at the tinvestigation, in my	opinion, death occur	and due to the cared at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)	
Propries after death. Funeral Director: After this certification by the funeral director, a	Certification; To	1	28e. Place of Inbuilding, el puilding, el nysician: To the best miner: On the basis of and manner st	ic. (<i>Specify</i>) of my knowledge, deal of examination and/or ated.	ath occurred at the tinvestigation, in my	opinion, death occurr se number	and due to the cared at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)	

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ORIGINAL

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AMEND ITEM#14, 18perFH, G887, 1713/09, WS

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10 2009 Jan. Nathaniel Burkett 11:45 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 18930 Middletown Rd. Baltimore Parkton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. Nov. 12 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ₩ 2 □ F Months Days Yrs ΜĎ Director 215-54-4885 60 1948 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10h. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shore Extrainer must be notified at Funeral Director 1 ☐Yes 2 ☐ No Baltimore Parkton 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 18930 Middletown Rd. 21120 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Black 11. Marital Status Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Completed by Specify 3 Widowed 4 Divorced "natural". 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver-Owner/Operator Trucking Business n/a other 18 Mether's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event ance. 17. Father's Name (First, Middle, Last) Be Charles Burkett Mabel Stanford (nee Smith) ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milford Stanford/brother 5608 Stonington Ave., Baltimore, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1/16/09 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Memorial Gardens Timonium, MD 4☐ Donation 5 ☐ Other (Specify) 21. Sunture of Funeral Convice Licensee Bryan W. Clary 22. Name and Address of Facility.
Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium. 23a. Part 1. Enter the disease, or complications that caus shock, or heart lailure. List only one cause on each limmediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 6 Months **Physician** UNG /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the furneral director, page 2 should be detached for use as the buriar-transit Records, P.O. Box 68760 Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month 2 □ No ☐ Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Division of Vital 1 ☐ Yes 2 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🗺 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 150232

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2009 ar **Physician** 05000 2.58 A MUW /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11000 (2n westmins 1000 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 8, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Year) 1947 1₺ M 2□ F 212-48-4167 61 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location and Mental Hygiene. marked other than "natural", or items 23a or 28a-f shov imatic event, the Medical Exeminer must be notified at 1 ☐ Yes 2 ☐ No Director Carroll Sykesville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 U.S.A. 6731 Marvin Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Completed by 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Painter Painting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Daniel Breighner Jr. Catherine Evans ဥ 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 923 DeSoto Road Baltimore, MD 21223 Mrs. Helen Frances Jonaitis/ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Jan. Date 5. 20c. Location - City or Town, State Department of Important: If It any Injury or o W Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Glen Burnie, MD Glen Haven Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funerel Service Licenses ono Services 1 Glen Burnie, MD 21061 2nd Avenue SW Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Finel 10(20013) **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical attending properties of IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) been signed by the should be detached it 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by Bleeding 27 No 1 TYes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed2 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No after death.

Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manne f Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled in the Funeral C completely filled in the following the second sec filled 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Day. Year) 29b. Signature and title of certifier 29c. License number 10059943 12,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Streer 295 Melmo 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00422 Reg. No 2009 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** M9 60; CJ 196 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** SUALKOAM SO FIEDEVILL N/A ALTEROLO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV 13, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Hours Days 1**X** M 2 □ F Yrs 195-32-1014 67 1941 Pennsýlvania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23s or 28s-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at PA Cumberland Newville 1 ☐Yes 217 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17241 3299 Ritner Hwy USA Apt 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{XN} \) 10 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married XXMarried Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2XXNo 2 Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0wner Auto Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John R. Bubb, Sr. Dora Hafer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau Christine Bubb 3299 Ritner Hwy Apt 1 Newville, PA 17241 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cumberland Valley Date 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 1/15/2009 Carlisle, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Maryland 21204 21. Signature of Juneral Service Licens 0 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HEMOCRAHAGS WTRACLAWIAL 304 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PTURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner pital or Attending Physician: The law requires that the death certificate be executed curs after ctorath.

The law serial rectorath.

The continuation of the attending physician and the carl Director. After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit filled in by the funeral director, page 2 should be detached for use as the burial-transit. resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 25 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 100 of Vital 1 ☐ Yes 2 200 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2€No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 € Apatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1-Alatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier

State Registrar

completely

(Check only one)

29b. Signature and title of pertifier

31. Date filed (Month, Day, Year)

HSSLGL

parke

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mary		artment of H <i>rtificate of L</i>		lental Hy	giene Reg. No.2	009	00423
	Physicia	an	Decedent's Name (First, Middle, Last Ollie		Present			2. Date of De Month	Day	Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, giv	Jean e street and number)	Bryant	4b. City, Town, or	Location of Death	Jan. 5	4c. Co	unty of Death	1745 М_
e .			Prince Georges			Cheve				ince Ge	
	Funeral Director		5. Social Security Number 578–58–8832 6. S		yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 10/10/	th 1 <i>y, Year)</i> 1942	9. Birthi Cou Miss	place (State or Foreign ntry) issippi
7	w all		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	ocation				1	0d. Inside City Limits
	a-f sho	ctor	D. C.	W	Mashingto	n					1. ZYes 2 □ No
	23a or 28	al Director	10e. Street and Number 4614 "G" Street	, S. E.		10f. Zip Code 20019				S . A .	ntry?
000	permit. Fages 1 and 2 should be filed within 7.2 hours after beauti with the maryanic Department of Health and Mentall Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination ust by retified at once.	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 \(\text{Yes} \) 2\(\text{T} \) No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 2√ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		Race - Americ Black, White, pecify: Bla	etc.
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V -	Hygie Ther th		12th 17. Father's Name (First, Middle, Last,)	DON	lestic	18. Mother's Name	e (First, Middle			yeu
	via per Vental I rked ol	To Be	William Bryant	,				Hollowa			
Mai	alth and I		19a. Informant's Name/Relationship (James A. Bryant	**		ng Address <i>(Street a</i>			-	own, State, Zij n , D . C .	
5 5 = 4	Fages 1 and the second of the		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Hemovai from State		osition (Name of matory or other plac ng Cemeter	111/14	Date /2009		tion - City or To ch Camp	own, State , Miss.
ם ב	permit. Departr Imports any Inju		21. Stature of Funeral Service Licer	Jacob S	2 - 4	2. Name and Addres W. H. B a c 4447 14th	on Funer	al Home	, Inc	gton, D	.C. 20010
			23a. Part / Enter the disease, or com shock, or heart failure. List only Imm. Jate Cause (Final	one cause or each line.		ter the mode of dyin					Approximate Interval Between Onset and Death
	hysician /Medical Examiner		disease or condition resulting in death)	a Due to (or as a co Hyperte	ensequence of):						
	2\ \ / ≒	iner	Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury	b. Due to for as a co							
	and and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co	nsequence of):						
0/00,	care be only sicial the buri	edical	· ·	Congest	ive Hear	t Failure	:				
O. DOX 0	Attending Physician: The law requires that the death certificate be executed at death. The death. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnanc☐ Other (specify) _	у		230	d. Date of deliv	ery Day Year
r SS	quires mar in signed b uld be deta	by P	Part II. Other significant conditions	contributing to death but no	ot resulting in the u	underlying cause giv	en in Part I.	23e. Did			he cause of death?
I Records	scertificate has bee irector, page 2 sho	Completed						24a. Was auto perfe 1 □ Yes		24b. Were auto prior to co death? 1 □ Yes	opsy findings available ompletion of cause of
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5	ding Physician: The I h. After this certificate ha funeral director, page	<u>2</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury	≥ ER/Outpatie		4 LI Nursing H	ome 5 Res			(fy)
SION	nding ith. : After e fune	ation	1 Natural 5 Pending 2 Accident investigatio	(Month, Day, Ye	ear) Injury	Worl	Yes 2 □ No	zod. Describe	now injury c	ocurred	
DIVIS	after des Director d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		At home, farm, st Specify)	reet, factory, office			Street and I wn, State)	Vum <i>b</i> er or Rur	al Route Number,
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	edical C		hysician: To the best of m miner: On the basis of ex and manner stated	amination and/or is						
	vithin To the compl	Me	29b. Signature and title of certifier	three	1	29c. Licens D589				signed (Month, nuary	
	5		30. Name and address of person who		h (Item 23a) (Type Hospital		v er ly, Md	. 20785	j		
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's				· · · · · · · · · · · · · · · · · · ·			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00424 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** 0237M Januar 09 105ep ·2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat **Examiner** General 0 lowa If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours 1 □ M 2 K F Days Min. Yrs Director 219 68 2865 27, 1935 England Dec. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examples must be notified at Director 1 ☐ Yes 2 No Ellicott City Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 9071 Upton Rd. 21042 filed within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: b 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Physical Therapist Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Doris Kate Marie Strevett traumatic George Agustus Silsbury 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 is any injury or other trau once. Leonard Baldwin / Son Ellicott City, MD 21042
Date 20c. Location - City or Town, State 9071 Upton Rd.; 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🙀 Burial 2 □ Cremation 3 □ Removal from State January 10, 4 ☐ Onation 5 ☐ Other (Specify) Woodlawn Cemetery 2009 Woodlawn, Maryland ral Sonice Licensee 21. Signa 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy. SE; Glen Burnie, MD 21061 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Mover ema hours disease or condition resulting in death) /Medical e to (or as a consequence of): Examiner disease s trug Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of): Examine he law requires that the death certificate be executed attending physician and for use as the burial-transit tension Cars P P Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Year signed by the a d be detached for 5 Other (specify) Ö 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>۾</u> 1 Xes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? ficate has 1, p.ge 2 st autopsy perform certificate **Division of Vital** 1 ☐ Yes 2 2 No or Attending Physician: this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA 1 Inpatient Certification: To After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturai 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) doctor ES -000 2009 0

State Registrar

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Housel Com

32. Registrar's Signature

Brown

Terrence

31. Date filed (Month, Day, Year). - -

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 00425 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OG, 2009 Month **Physician** Edith G. Beckman lanuar 7:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Fahrney-Keedy Nursing Home Boonsboro Washington 8. Date of Birth (Month, Day, Nov 17, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** ^{Year)}1918 Months Days Hours Min. 90 162-07-5314 Pennsylvania Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show perm it. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any nijury or other traumatic event, its Medical Exactional by nortified an once. MD Washington Director Boonsboro 1 ☐ Yes 2√☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8507 Mapleville Road 21713 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 🏋 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk waitress food_industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Israel Gibble Ida Zug 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn Byers/daughter 9307 Snow Hill Estates Lane Laurel, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service L Ronald 8 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 23a. Party. Enter the dise se, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Sause (Final Coronary **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hyperten Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine brillation The law requires that the death certificate be executed burial-transit Atrial and Due to (or as a consequence of): attending physician for use as the buria Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed director, page 2 should has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate Division of Vital 1 ☐Yes 2 ☐ Ño 1 □Yes 2 □ No e Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral (27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5060396 06

State Registrar FARID

31. Date filed (Month, Day, Year)

1126

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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n-

32. Redistrar's Signature

SHED

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00426 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** A^{M} 8, 2009 Delmar M. Byroade January 1:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince George's Clinton 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min 1፟፟፟∭ M 2□ F Months Days Hours March 19, 1920 Director 88 310-18-4755 Ohio Usual Residence of Decedent les I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

If them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, It is Nectical Evanting must be notified at 10a, State 10c, City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Indiana Allen New Haven 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 11926 U.S. 30 East U.S.A. 46774 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 \times 2 \sum No 12/22/42 Black, White, etc. 1 ∑Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify. Completed by 3 ₩ Widowed 4 Divorced 11/23/43 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator House Siding Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harley Byroade Bonnie Sleesman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 11627 Sygnet Dr., Waldorf, MD 20604 Diana Krieger (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important; If It any injury or o 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 1/13/09 5 ☐ Other (Specify) I.O.O.F. New Haven, IN uneral Service I cen 22. Name and Address of Facility E. Harper & Son Funeral Home 21. Sign ture of 740 State Road 930 East, New Haven, IN 46774 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final oscles. Lestinows **Physician** disease or condition resulting in death) /Medical is a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of) physician by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Year Day signed by the a 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No P.O. ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 2 110 1 □ Yes Physician: 24 hours after death.

e Funeral Director: After this certific letely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a, Certifier and manner stated within 2 To the I 29b. Signature as 29d. Date signed (Month, Day, Year) 64 30. Name and address of person who co mpleted cause of death (Item 23a) (Type, Print) 3 31. Date filed (Month, Day, State Registrar 2 2000

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Nicholas Tyler Byro		S			d / Depar	tment of	Health an	d Mental H	lygiene	ibic.		
- 20-01	R	For State egistrar Decedent's Name (First, Mide	lle Leet)		Cert	ificate of	Death ———		Reg	. No. 2	0 0 9 3. Time	0042
Physician/ Medical Examine		NichoL	95	T	BYRG	oN .	0". T		Month January 11		052	26 hrs
	4	 a. Facility Name (if not instituting Route 97 south of Ol 			er) /	40	Westminste	Location of Deat		Carroll	Death	
Funeral	5	. Social Security Number	6. Sex		Age (In yrs. las	st birthday)	If Under 1 Yea		_ /	(MM/DD/YYYY)		(State or Foreign
Director	1	89-72-8823	1 M	2F		7 Yrs.	Months Day	s Hours Mil	02/08	11991	Country) HANOUE	R. PA
a	-	Isual Residence of Decedent			Idoa City 3	Town or Locatio					114	side City Limits
ow any	1	Oa. State 10b. County	Lan	<i>e</i> ,	Toc. City,	Fown or Location	-	4.1				Yes 2 No
a-f sho t once		0e. Street and Number		2	1 4	11116	570W 10f. Zip Code	<u>/U</u>	10	g. Citizen of Wh		
with the Maryland ms 23a or 28a-f show be notified at once. eral Director			STOU	ni R	ad	ł	173	40		11.5	A	
with t ms 23a be not		Marital Status	13	2. Was Deced	ent Ever in U.S			spanic Origin? (S n, Mexican, Puert	Specify Yes or No-	14. Race White	- American Indi	an, Black,
or items 22			Married 1	Armed Forc	es? 2 No		_/		o Ricari, etc.)		Blac	·K ·
s after rral", niner		Widowed 4 D 15. Decedent's Education (Sp	or	Yes, Give Year Dates:	2008		Yes 2 V No	specify:	work done	Specify: 16b. Kind of But	Siness/Industry	· /\
2 hour "nate	-	Elementary/Secondary (0-12		College (1-4		during mo	st of working life	DO NOT use re	tired)	1		
5-0036 led within 72 hours aft Hygiene. other than "natural the Medical Examine Completed by		11				5	TUDENT	•		HIGH	Schoo	<u>L</u>
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		7. Father's Name (First, Middl	e, Last)					0	ne (First, Middle, M		a 1	-
21214 ould be fill d Mental F s marked fic event, I		9a. Informant's Name/Relation	NOLU	e. Print)		19b. Mailing	Address (Stre	URENC et and Number or	Rural Route Num	ber, Oity or Town		ode)
, MD 21 and 2 should earld and Me earlt and Me early is me traumatic er To	1	BRENDA S. CO	111	MoThe	FR	725		TOWN	Road Li	TLESTER	()	17340
ore, Nest and of Health If item	-13	20a. Method of Disposition 1 Surial 2 Cremati	2 🗆	Domayal from		Place of Disposi rematory or oth		emetery,	Date	20c. Location -	City or Town, S	State
altimore, rmit. Pages Lar epartment of He proriant: If ite jury or other tr		4 Donation 5 Other		Removal non		cred He	art Cep	retery 01/	15/7009	HANOU	R, PA	17331
Baltimore, MD 21215-00. permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other i injury or other traumatic event, the Men		21. Signature of Funeral Service	e License	1	,	22. N	ame and Addres	E L		FUNERA		
Physician	V	23a. Part I. Enter the disease,	or complete	ations that cau	sed the death.	Do not enter th	E MZ e mode of dying	AIN ST.	or respiratory arre	IINSTER est, shock, or hea		21157 oximate Interval
/Medical		failure. List only one caus	e of each	line.	t Force Inju						Betw	veen Onset and Death
Examiner		Immediate Cause (Final diseas or condition resulting in death)	_		onsequence of				1		- 1	
		Sequentially list conditions,	b	a to for as a s	onsequence of	٠.					_	
and and		if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated	e c									
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60, ate be ohysicial burial to buria		F FEMALE:		23c. If yes, ou	tcome of pregr	nancy				23d. Date of	delivery	
687 certific ding p	2	3b. Was decedent pregnant in past 12 months?	the	1 Live birt	th nt at time of dea	_,	al death 3	Ectopic preg	nancy	Month	Day	Year
box 68760 the death certificate by the attending physiched for use as the bubby electron Management of the control of the cont		1 Yes 2 No 9 U	nknown	9 Unknow		atn 5 Oth	ner (Specify)					
O. E at the at the d by the stached		Part II. Other significant con	litions co	ontributing to o	death but not re	esulting in the u	nderlying cause	given in Part I.		bacco use contr	_	
S, P. irres th										2 V No 3		
ord: w requasition as been as	bie								24a. Was a autop:	sy r	prior to completed death?	ndings available on of cause of
Records, I The law requires freate has been sig	١			t)					1 ✔ Yes		✓ Yes	2 No
Division of Vital Records, P.O. Box 68760, rate or Attending Physician: The law requires that the death certificate be an Directorary. After this certificate has been signed by the attending physical in by the funeral director, page 2 should be detached for use as the buserification. To Bo Completed by Physician Management	n	25. Was case referred to medi examiner?		spital:	patient 2	ER/Outpatient		Other Nurs		Residence 6	Other: Scene	
of V g Phys rer this	<u>-</u>	1 ✓ Yes 2 No 27. Manner of Death	1_	28a. Date of	f Injury	28b. Time of I		ury at Work?	28d. Describe h	now injury occurr		
on c ending auth.			nding	Jan 11, 2	009 ^{ear)}	0512 hrs	1	Yes 2 V No	Driver auto i	ollover		
visi	<u> </u>	3 Suicide 6 Co	vestigation ould not be	28e. Place		ome, farm, stree	et, factory, office	building, etc.	or Town, S	Street and Numb tate)		. ,
Di Spital nours a neral J	Certification:	4 Homicide	termined			d / Highway			Route 97 sout	h of Old Hano		estminster, MD
	Medical	29a. Certifier 1 Certifying (Check only one) 2 ✓ Medical E	kaminer: 0	n the basis of	examination a	ge, death occur nd/or investigat	red at the time, ion, in my opinio	date and place, a on, death occurred	nd due to the caus d at the time, date	e(s) and manner and place, and c	as stated. lue to the cause	∋ (s)
To T	Med	29b. Signature and title of cert	a	nd manner sta	ited.			se number			ed (Month, Day	
		11/10	-	nop)		0.0	M.E.		January 11	, 2009	
01	ŀ	30. Name and address of pers							MD 04004			
,		Russell Alexander N		- 11	edical Exam		Penn Stree	t, Baltimore,	VID 21201			
Stat Registra		31. Date filed (Month, Day, Yea	ากด	SZ. Reg	jistrar's Signatu	back	<i>j</i>					
DHMH 17 Rev 1/200)1	61 5 5 1 5 mm	০ লাভ ্র	,	1	ORIGINA	L		C	CME		

amend #5 Per Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3,200⁹ **Physician** January 1:50 AM Blocker /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Georges Hospital Cheverly Prince Georges If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 251 255 – 18 – 4538 7. Age (In yrs. last birthday) 6. Sex **Funeral** Year) 1 X M 2 □ F Months Days Hours 24,1920 South Carolin 88 Nov. Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b County or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 No Director Capital Heights MD Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20743 Cindy Lane #303 Funeral within 72 hours after death 12. Was Decedent Ever in US Armed Forces? 1942— 1 MYes 2 □ No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 XNo Specify Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) filed withir I Hygiene. Fork Lift Operator Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental h pe Carrie ပ္ James Blocker Blocker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1 C1ndy Lane #303
Capital Heights, MD 20743 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Bettie Blocker/WIfe 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Maryland Veterans Cemetery 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Jan 14,09 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility AUstin Royster Funeral Home 14th Street, NW, Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final un **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed and Due to (of as a consequence of) burial physician s the burial Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death
9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) P.0. signed by the a d be detached f 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? uting to death but not resulting in the underlying cause given in Part I. Division of Vital Records. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death? has page 2 : autopsy performed? certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📉 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Magner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation after death.

Director: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29c. License numbe 29b. Signature and title of certifie 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VINC 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Amend #8 per FH g887 1/13/09 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 6:00 AM rown 08 2009 Januari /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner House 1saltimore tas 8. Date of Birth Dec. 9 9. Birthplace (State or Foreign (Month, Day, Year) 1016 - Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last hirthday) **Funeral** 216-24-789 Usual Residence of Decedent Year) 1916 Mary Land 1 M 2 F Months Days Hours Min 92 Director 10c. City. Town or Location 10d Inside City Limits 10a State 10h Counts 28a-f show th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Expression mast be profilled at 1 ☐ Yes 2 No Director Md. Baltimore Essex 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21221 U.S.A. 323 Lorraine Avenue Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No 2 Specify Specify: 3 ☐Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f permit. Pages 1 and 2 should be Department of Heath and Menta Important: If Item 27 is marked any injury or other traumatic evonce. Klementyna Groeholski George Mizejewski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlene D. Wilhelm/Daughter 320 Pine Valley Drive Felton, PA.17322 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 1-13-2009 Baltimore, Maryland Holy Rosary Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Raczorowski Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each li Immediate Cause (Final disease or condition resulting in death) **Physician** 25 mellitus 2120 Vears /Medical Due to (or as a consequence of): Examiner LOW Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to lor as a vascular disease The law requires that the death certificate be executed Vear attending physician and for use as the burial-transi neval Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) signed by the a d be detached for P.0. 9 HInknown 9 Unknowi 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Ş 2 No 3 Probably 4 Unknown 1 Tes After this certificate has been si funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence Stother (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred I or Attending Fafter death. 1 Natural 2 Accident 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun. 1 ☐ Yes investigation 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

State

Registra DHMH 17 Rev 1/2001 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MM

Mina

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Benson

Registrar's Signature

3320

Avenue

29c. License number

29d. Date signed (Month, Day, Year)

			Please	e Type or Prin				•	•	
			For State Registrar	State of Ma		artment of I <i>rtificate of</i>	Health and Me Death	, ,	giene Reg. No. 2000	0 001.20
	(4.2	v	Decedent's Name (First, Middle, I	Last)				Date of Dea	ath	3. Time of Death
9	Physici /Medic		Delores A	A. Brzez	ensk <u>i</u>			Month J <u>anua</u>	ry 8,2009	1:00A. [™]
	Examin		4a. Facility Name (If not institution, g			_	or Location of Death		4c. County of Dea	
-			ManorCare of 5. Social Security Number 6		e (In yrs. last birthday)	TOWS		. Date of Birt	Baltim	
34	Funeral Director		219-28-1204 Usual Residence of Decedent	1□ M 2/□	77 Yrs.	Months Days	Hours Min.	Month, Day July3	y, Year) C	thplace (State or Foreign ountry) ryland
	yland low at		10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	e Mar Sa-f sk tiffed	ctor	Md. Balti	lmore	Eastwo	od				1 ☐ Yes 2 ☐ No
	vith th	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	eath v	eral	7218 Bridgewo	ood Drive 12. Was Decedent 6	Everin U.S. 13	Was Decedent of		tv Yes or No	USA 14. Race - Am	erican Indian.
336	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	Armed Forces?	10	If Yes, specify Cut 1 ☐ Yes 2 No	Hispanic Origin? (Specifoan, Mexican, Puerto Ric Specify:	can, etc.)	Black, Whi	te, etc.
21215-0036	72 hor	Completed	15. Decedent's (Specify only highest	Education	16a. Dece	edent's Usual Occu	pation during most of working		16b. Kind of Business	/Industry
21	vithin ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5	+) life.	DO NOT use retire Sales	during most of working ed)		Hochild-	Kohn
	filed within Hygiene. other than ent, the Me		12 th 17. Father's Name (First, Middle, La	est)			18. Mother's Name (I	First. Middle.		KOIIII
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Maryland	2 should be f and Mental F is marked of aumatic eve	F	19a. Informant's Name/Relationship	(Type. Print) Hust	and 19b. Maili	ing Address (Stree	t and Number or Rural F		er, City or Town, State,	Zip Code)
	1 and 2 Health a tem 27 is		Edmund H. Brz	zezenski				re Ba	ltimore,	Md. 21224
ore	of He of He if item or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	☐Bemoval from State	20b. Place of Disponentery, cre	osition (Name of ematory or other pla	Dat	e	20c. Location - City of	r Town, State
Baltimore,	. Pages treent of the tant: If ite		4 Donation 5 Other (Spe	cify)	Oak Law	n Cemet	ery 1-10-	2009	Baltimor	e,Maryland
Bal	permit. Pages 1 al Department of Hes Important: if item any injury or othe	J. J	21. Signature of Funeral Service Li	2	1	201 Dur	ıdalk Aver	ue B	altimore,	
	Physician /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. Alzh	the death. Do not en ne.	1	ing, such as cardiac or i	respiratory a	rrest,	Approximate Interval Between Onset and Death
٦	Examiner			Due to (or as	a consequence or,					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C						
60,	be ex ician (burial		and the second s	Due to (or as	a consequence of):					
687	certificate be executed iding physician and ise as the burial-transit	adic		d						
Box	ath utter	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death 3	□Ectopic pregnan □ Other (specify)	су		23d. Date of de Month	elivery Day Year
P.0	uires that the de signed by the a	, Ph	Part II. Other significant condition	s contributing to death b	ut not resulting in the u	underlying cause g	iven in Part I.	23e. Did to	obacco use contribute	to the cause of death?
rds	quires n sign ıld be	d by						1 🗆 '	Yes 2 520 No 3⊟F	Probably 4 Unknown
Records,	ding Physician: The law requir n. After this certificate has been si funeral director, page 2 should I	Completed							osy prior to ormed? death?	
Vital	lan: 'rtifica'	Be C	25. Was case referred to medical examiner?				26. Place of Death (1□ Yes Check only o	2 ^t No 1 □ Ye nne)	s 2 N ;No
or V	Physician: r this certificaral director,	ToE	1 Yes 2 YoNo	Hospital: 1 ☐ Inpatie	ent 2 ☐ ER/Outpatie	ent 3 DOA	ther: 4 Vursing Home	e 5 □ Resi	dence 6 □Other (Sp.	ecify)
o u	ing P	:uo	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da		We		d. Describe	how injury occurred	
Division	or Attending after death. Director: After in by the fune	Certification:	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be 28e. Place of inju	ury - At home, farm, si c. (Specify)		Yes 2 No 28	f. Location (3 City or Tou	Street and Number or F wn, State)	Rural Route Number,
_	Hospital 14 hours (Funeral tely filled	Medical Ce	29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the best xaminer: On the basis o and manner st	f examination and/or i	ith occurred at the nvestigation, in my	time, date and place, ar opinion, death occurred	d due to the	cause(s) and manner a	as stated. ue to the cause(s)
		Me	29b. Signature and title of certifier	Avoo	lu Do		nse number 054424		29d. Date signed (Mor	
	8		30. Name and address of person w	ho completed cause of d	eath (Item 23a) (Type					
	U		Cyrus Asadi	120E,7	monun	n rdi#	209 Timo	nicen	MOZI	073
	St Regist	ate rar	31. Date filed (Month Div Year)	2009 32. Registr	ar's Signature	Garled				
DI	MH 17 Rev 1/2				1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Carolyn V. Cropsey
4a. Facility Name (If not institution, give street and number) 11 2009 4c. County of Death 17:23 PM /Medical January , 4b. City, Town, or Location of Death Examiner Havre de Grace Ha If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Harford Memorial Hospital Harford If Under 1 Year Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1 ☐ M 2 🗷 F Yrs. Director 03/10/1937 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Harford MD Forest Hill 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 1704 1 C Rich Way 21050 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: Never Married 2 ☐ Married 1 ☐ Yes 2 No 5-0036 Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Elementary/Secondary (0-12) Never Worked College (1-4or 5+) iges 1 and 2 should be filed within of Health and Mental Hygiene. Never Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ္ပ Joseph H. Cropsey Carolyn Courtney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 any injury or other tronce. JoeAnn Appleby/Sister 1704 1C Rich Way Forest Hill, MD 21050 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 18 Burial 2 ☐ Cremation 3 ☐ Removal from State Jan 14 4 Donation 5 Other (Specify) Baltimore Cemetery | 22. Name and Address of Facility 2009 Baltimore, Maryland permit. 21. Signature of Funeral Service Licensee M01443 Cremation and Funeral Alternatives 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the more of ying, such as carolac or respiratory arrest, shock, or heart failure. List only one cause on each line. Maryland
Approximate
Interval Between
Onset and Death
UN KNOWN Immediate Cause (Final disease or condition resulting in death) Due to (or as a construence of): **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and burial-trar Due to (or as a consequence of) physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day for in the past 12 months? 1 ☐ Yes 2 ☒No Month Vear 4□Pregnant at time of death 5 Other (specify) the 9 I Inknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed?

1 Yes 2 No Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 1 🔣 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification:

Division or Vital Records, P.O. Box 68760 cropsey, Caroly1

After t To the Hospital or Attending 24 hours after death. filled in by the within 24

1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

Physician MO

and manner stated

29c. License number 120065421 29d. Date signed (Month, Day, Year) 01,11,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Avenue, Havre de Grace, MD 21078

Fistler Christa 31. Date filed (Month, Day, Year)

JAN 13

South 501 32. Registrar's Signature

Barks

2

Registrar

State

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 30 am 91 13-09 VanBuren Chilcoat /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner timore oseca le 40501 tal (enter Birthplace (State or Foreign Country) 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 4 **Funeral** Months Hours 1 XM 2 ☐ F Director 2/25/1933 Maryland 219-28-5163 Usual Residence of Decedent 10c. Cify, Town or Location 10d. Inside City Limits 10a. State 10b. County and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 25a or 28a-f show is marked other must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Essex 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 713 Middlesex Road S. A. 14. Race - American Indian, Funeral 21221 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Chileat, Vanbyren Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: ģ 3 Widowed 4 Divorced 1955 White Completed Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any injury or other traumatic event, the Medical I once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Melvin VanBuren Chilcoat Bertha Adele Cunningham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mollie Chilcoat (Wife) 713 Middlesex Road Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Burial 2 □ Cremation 3 □ Removal from State 1/17 2009 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery Parkville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 Lichard 23a. Part1. Enter the disease or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sep5.5 Due to (4r as a consequence of): **Physician** 2 da 45 /Medical **Examiner** neumonia Sequentially list conditions, if any, leading to immediate cause. Entire cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed ongestive the burial-tran Due to (or as a consequence of): P.O. Box 68760 aftending physician for use as the buria Physician/Medical ardio mu IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown cate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 12 No certificate 1∐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manne Death 28b. Time of 28d. Describe how injury occurred 1 Latural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No s after death 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

To the Hospital or Attending Physician: within 24 hours a completely

State Registrar 29b. Signature and title #

tho completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person

Franklin Square Drive Baltimore, Md 21237 1000 29 Kamly 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			1 - State Registrar		artment of Heal rtificate of Dea		Reg. No 2 0	2 0 0
	Physicia		1. Decedent's Name (First, Middle, Last) Richard H. Clayton			2. Date of Dominate Month Januar	Day	3. Time of Death 9 Sivo P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number	er)	4b. City, Town, or Local	tion of Death	4c. County o	Death
•			Ivy Manor 5. Social Security Number 6. Sex 7	Age (In yrs. last birthday)	Ellicott Ci	•	Howard	9. Birthplace (State or Foreign
	Funeral Director		141-24-8215 1X № 2□F	90 Yrs.	Months Days Ho			Country)
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Maryl	tor	MD Howard	Ellicott				1 □Yes 2 X No
	or 28s	Direc	10e. Street and Number	111110000	10f. Zip Code		10g. Citizen of Wh	nat Country?
	s 23a	Funeral Director	2928 Normandy Drive		21042		USA	
136	be filed within 72 hours after death with the Maryland tal Hygiene. It with then "natural", or items 23a or 28a-f show do other then "natural", or items 23a or 28a-f show event, it a Modical Exacities of the profiled at	by Fun	11. Marital Status 1 □ Never Married 2 Married 1 □ Never Married 2 Married 1 □ Yes 2 If Yes, Give 3 □ Widowed 4 □ Divorced	No.		c Origin? (Specify Yes or N xican, Puerto Rican, etc.) ecify:		- American Indian, White, etc. White
1215-0036	72 hou natura lical E		15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation	mant of working	16b. Kind of Busi	
	filed within 72 Hygiene. other than "nai ent, the Medic	Completed	Elementary/Secondary (0-12) College (1-40	(+C+)	kind of work done during DO NOT use retired)			
N.	filed v Hygie other t		17. Father's Name (First, Middle, Last)	Drait	sman/Designe	er Mother's Name (First, Middle	Avionics , Maiden Surname)	
/lan	2 should be to and Mental is marked of aumatic eve	To Be	Harry Clayton		Ali	ice Maud Smit	h	
Maryland	ges 1 and 2 should it of Health and Mer If Item 27 is marke or other traumatic	ľ	19a. Informant's Name/Relationship (Type. Print)			umber or Rural Route Numb		tate, Zip Code)
e, e,	1 and 2 Health tem 27 i		Ruth S. Clayton/Wife 20a. Method of Disposition			son, MD 21204	20c. Location - C	ity or Town State
Ē	Pages ent of nt: If It ry or o		1 ☐ Buria! 2 🕱 Cremation 3 ☐ Removal from State	e	osition (Name of matory or other place) ematory, Inc		Baltimore	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Licensee C. Tod			ciety of Mary Rd Baltimor	land, Inc	2, FID
			23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death. Do not en				Approximate Interval Between
F	hysician		Immediate Cause (Final		CARDIO VASC	ULAR DISEAS	جي.	Onset and Death
E	/Medical Examiner		Due to (or a	as a consequence of):				
4		ner	Sequentially list conditions, if any leading to transport to transport to transport to the course of	es a consequence of):				
	and -transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a					
09/00,	rinicate be executed by physician and as the burial-transit	alE	Due to (or a	is a consequence of);				
00	ng phy as the	ledical	d		-			
Š į	ttendir	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcom		☐ Ectopic pregnancy		23d. Date	
5	/ the a	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant 9 ☐ Unknown 9 ☐ Unknown	at time of death 5	Other (specify)		Monti	n Day Year
ν. Γ	med by	by Ph	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause given in P	art I. 23e. Did	tobacco use contrib	ute to the cause of death?
ecords,	equine sen sig ould b					10	Yes 2 No 3	☐ Probably 4 ☐ Unknown
ည်	has be	Completed				24a. Was	psy prie	ere autopsy findings available or to completion of cause of
VII I	ficate r, pag			·		perfo 1 □ Yes	ormed? dea	ath?]Yes 2 □ No
-	s certi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inna	tient 2 ER/Outpatier		lace of Death (Check only o		ASS ISTED UVING
5	ter this	n: To	27. Manner of Death 28a. Date of Ir				how injury occurred	
SIOIS	eath. or: Af the fu	catic	2 Accident investigation		M 1 □Yes 2	2 □ No		
DIVISI	To the propried of Attenuing Frigstoans. The law requires that the death centificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	4 Homicide determined 28e. Place of I building,	njury - At home, farm, str etc. <i>(Specify)</i>		City or To	wn, State)	or Rural Route Number,
	Funer Funer (tely fil	Medical	29a. Certifier (Check only one) Certifying Physician: To the best and manner: and manner:	of examination and/or in	h occurred at the time, dat vestigation, in my opinion,	te and place, and due to the death occurred at the time,	cause(s) and man date and place, and	ner as stated. d due to the cause(s)
á	2 40 00				OOs Lissass sumb	ner	29d Date signed (
To sho U	within 2	Me	29b. Signature and title of certifier		29c. License numb			Month, Day, Year)
To sto U	within 2 To the comple	Me	29b. Signature and title of certifier Mo)				
	within To the comple	Me	30. Name and address of person who completed cause of					Month, Day, Year) L, 2009 LUMSIA, MO ZIOYY

State of Maryland / Department of Health and Mental Hygiene 2 0

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Physician
/Medical
Examiner

Funeral Director

ortant; If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, Ite Medical Examinat to notified at permit. Pages 1 and 2 s Department of Health ar Important; If Item 27 is

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

burial-trar P.0. Vital of Division

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Eileen Estell Cooney January 4:15 p 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore Timonium | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Days | Per 12 1926 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2X F 213-26-7835 82 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane, HR-214 21228 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify. Specify: 3X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Thomas Riley Janie May Chambers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2130 Ganton Green, 301C, Woodstock, MD 21163 Ethel J. Kanode - sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metro Crematory, Inc.01/08/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servic Steven H. Williams Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD Huly. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: $4 \square$ Nursing Home $5 \square$ Residence 6X Other (Specify) **HOSPICE** Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifier (Check only one X Nurse Practition Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Nurse Practitionnermer stated. 29b. Signature and title of certifie 29c. License number K157629 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JENNIFER HAUF, CRNP TIMONIUM, MD 21093 3 Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 3 2009 Registrar A. faces

124 hours a

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09-00230

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Wellner L. Christian State of Maryland / Department of Health and Mental Hygiene 2009 00435 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day January 8, 2009 1120 brs Medical Examiner Wellner L. Christian, Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert 11981 Lexington Drive Dunkirk If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign District **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) Hours Director 228-78-3617 1**X** M 2 55 JUN 30, 1953 Country f Columbia Vrs Usual Residence of Deceden 10a. State 10c. City, Town or Location 10d. Inside City Limits Yes 2X No MD Calvert Dunkirk death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 11981 Lexington Drive 20754 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 197 1 X Yes 10 1984 Yes, Give Year 2 X No specify: White hours after Widowed Yes Specify: Divorced à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 | is marked other than " 21215-0036 5+ Aeronautical Engineer **US Navy** Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wellner L. Christian Poppy March (Street and Number or Rural Route Number, City or Town, State, Zip Code)22304 ٩ 19a. Informant's Name/Relationship (Type, Print) P Dianne Diane Christian/Wife If item 27 i 260 South Reynolds St, Apt 1103 Alexandria, VA 20a. Method of Disposition timore. Burial 2 X Cremation 3 crematory or other place) Removal from State tant: Metro Crematory, Inc 1/10/09 Baltimore, MD Other Specify 21. Signature of Funeral Service Licensee C. 22. Name and Address of Facility Cremation Society of Maryland, 299 Frederick Rd Baltimore, MD Todd Dring 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Morphine intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last death certificate be executed and Physician/Medical 12,19a per fh g887 1-20-09 vt #1, 23a,27,28a-f, per ME g888 physician a X UNPENDED x AMENDED Box 68760 IF FEMALE: 23d. Date of deliver 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death Dav past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown The law requires that the Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ≥ No 3 Probably 4 ✔ Unknown Yes 2 Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? Yes 2 V No the Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) Division of Vital æ Other₄ examiner? Hospital: Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 V Yes ٩ No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural unk Yes 2 XNo death Director: Pending Fd 1/8/09 Fd 11:22 am 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 11981 Lexington Dr Dundalk. MD 28e. Place of Injury - At home, farm, street, factory, office building, etc hours after 3 Suicide XCould not be residence determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. January 9, 2009 Crasul 30. Name and address of person who completed cause of death (Item 23a) okpera Assistant Medical Examiner Melissa Brassell, MD 111 Penn Street, Baltimore, MD 21201

State

Registra

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Registrar's Signatur

31. Date filed (Month, Day, Year

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 2005 January 10, 7:05 РΜ Dorothy Jean Cooper /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Center Towson 8. Date of Birth (Month, Day, Year Dec. 20, 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Year) Months Days Hours Min. Director 220-12-9466 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, I'm Madical Evanting must be notified at 1 ∐Yes 2 X No Director MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2525 Potspring Road #S422 21093 Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Armed Forces? 1 ∐Yes 2 🛛 No 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo If Yes, Give Year or Dates Specify: ۵ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) filed withir I Hygiene. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marian Gore Charles Gill ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other trau Edward Cooper/Husband 2525 Potspring Road #S422 Timonium, MD 21093 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date January 11, 1 ☐ Burial 2 🖾 Cremation 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 2009 Glen Burnie, MD 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 21. Signature of Fu ice Licer see Michael Flagle Timonium, MD 21093 10 W. Padonia Road Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) 0111 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Disk to (or as a consequence of) be executed physician and the burial-transit Exami Box 68760, ⋈ Due to (or as a consequence of): Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a o 9 Unknown 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 ☐ Yes 2 🗹 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an cate has page 2 s certificate 1 □ Yes 2 No After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1☐Yes 2☐No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending investigation To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11,2009 w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) balto md 2:204 N. Cha 6201 6 31. Date filed (Month, Day, Registrar's Signature Year)_ Registrar

			For State State Registrar	ate of Maryla		artment of F rtificate of I			en <u>2</u> €009 . No.	00437
	t pr	54	Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
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Ľ	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2		s. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y 10/31/19	ear) 9. Birt Co	hplace (State or Foreign untry) MD
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventinal results to notified at once.	þ	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 X N If Yes, Give Year or Dates:	0		1 □Yes 2 ሺ No	Specify:		Specify: Wh	nite			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00439 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ciborowski **Physician** Lillian в. Month 11:00 PM January 10,1 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Timonium Baltimore 7. Age (In yrs. last birthday) 88 Yrs. If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 219-01-7065 **Funeral** 1 □ M 2 🛛 F **Director** March 15, 1920 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at MD Baltimore Edgemere Director ¹X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2825 Lodge Farm Road, Apartment 120 21219 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No White Specify. δ 3X Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Labor Worker Food Service Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname)
Anna Suchocka 17. Father's Name (First, Middle, Last)
Matthew Kalejta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryann Battaglia / Daughter 3312 Northway Drive, Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 01/12/2009 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD Mar Shall 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LIVER CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Tigury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and s the burial-trans Due to (or as a consequence of) Physician/Medical as Box (IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify). □Yes 2XNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 X No Vital 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Hospital: 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: Division 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifier | 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only Onex Nurse Practition Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Nurse Practition Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 29b. Signature and tifle of contifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

2300 DULANEY VALLEY RD.

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

JACKIE JONES

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TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2 55 **Physician** Canaday Roland Francis Jr. conuar /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctors Community Hospital Prince George's Lanham 8. Date of Birth (Month, Day, Year)
Jan. 11, 1 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ F Ĩ958 50 Director Texas 131-54-5806 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Widon Exa. in contact that contact once. 1 ☐ Yes 2√∑ No Director Maryland Prince George's Capital Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 6058 Old Central Avenue 20743 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify If Yes, Give Year or Dates: ۾ Specify: **Black** 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Apostle (Pastor) Ministry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roland Canaday Sr. Ivy Irving ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Sister) 740 East 178th Street, #11F, Bronx, New York Diane Canaday 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Jan.10,2009 Morganville, NJ Forest Green Park 5 ☐ Other (Specify) 22. Name and Address of Facility Strivers Row Funeral Home, 21. Signature of Fineral Service Livenses 10037 416 Lenox Avenue, New York, NY annes ! dun 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final espiration Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine Clostnidia physician and s the burial-trans severe resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, þ Physician/Medical use as t attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) the 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۾ Interction 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page certificate | 2 🗆 No 1 ☐ Yes 2 **H** 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 40 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 29a, Certifier 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MDD 606 11 200 MD

State

Registrar

MO

\$2. Registrar's Signature

8118 6000 LUCIE ROAD LANTAN, MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 2009

31. Date filed (Month, Day, Year)

			State of Maryland / Dep					
			Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of	Death	2. Date of Dea	Reg. No. 2005	3. Time of Death
н	Physici /Medic		Doris Crandell			Month Januar	Day Year	10:54 A.M
and to	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	or Location of Death		4c. County of Dear	th
			Harbor Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		timore	0 D-11 D: #	N/A	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 M 2 1 N 2 1 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 11/12/1		thplace (State or Foreign buntry) aryland
	0		Usual Residence of Decedent			11/12/1	1921	
	faryla sd.t.	ō	10a. State 10b. County 10c. City, Town or L Maryland Anne Arundel Baltin					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28a-	Director	Maryland Anne Arundel Baltin 10e. Street and Number	10f. Zip Code		1	l 0g. Citizen of What Co	**
	th with		177 West Meadow Road	. 2	21225		U.S.A.	
98	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural" from high mattle event, thu "natural Examinat mattle be notified at	y Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No	. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🛣 No	Hispanic Origin? (Spe pan, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	Specific	e, etc.
Maryland 21215-0036	hours tural"	ed by	3 LXWidowed 4 LI Divorced Year or Dates:	edent's Usual Occu		1	16b. Kind of Business/	hite
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21	ed witi ygiene ier the t, the	Com	12th Se	cretary			Bank	
and	2 should be filed wind and Mental Hygier Is Is marked other thranked other thranked event, Incommatic	Be	17. Father's Name (First, Middle, Last) John Henry Graefe		18. Mother's Name		_{Maiden Surname)} beth Schwei	kort
Ž		ပ္		ling Address (Stree			r, City or Town, State, 2	
	es 1 and 2 sof Health au Item 27 Is rother trau			West Mea			more, Mary	
ore	jes 1 e of He of Item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cre	position (Name of ematory or other pla	Da		20c. Location - City or	
	Pa int int		4 Donation 5 Other (Specify) Cedar Hi	11 Cemete	ery 01/06	5/2009	Baltimore,	Maryland
Ra	permit. Departr Importa any Inju			22. Name and Addre	GOI	nce Fune	eral Servic	e, P.A.
			23a. Part1. Enter the disease of complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	14001 KITC	ing, such as cardiac or	r respiratory arr	est,	yland 21225 Approximate
May .	Physician		shock, or heart failure. Let only one cause on each line. Immediate Cause (Final disease or condition FUPTURED THOR			ANGI	1	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):					
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×*	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.			DISGA	se-	
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ñ i	atter atter for u	Physician/Me	in the past 12 months? 1 Live birth 2 Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	су		23d. Date of del Month	Day Year
ב י		by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause giv	ven in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
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i	sician: The faw certificate has b irector, page 2 sl	S				perform		
VITA	Pnysician: r this certific ral director, I	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Innatient 2 ☐ FB/Outnatient	Oth	26. Place of Death			
_	D 0 0	<u>ان</u>	27. Manner of Death 28a. Date of Injury 28b. Time of	SIR 3 LI DOA	4 LI Nursing Hom		ence 6 Other (Spec	cify)
100	Attending ir death. ector: After by the fune	atio	1 Natural 5 Pending (Month, Öay, Year) Injury 2 Accident investigation		rk?]Yes 2□No			
DIVISION	tal or Att rs after de al Directo ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	20	8f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,
	o the Hospital of Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	edical	29a. Certifier (Check only one) 1☐ Certifying Physician: To the best of my knowledge, deal can be seen to make the composition of the basis of examination and/or in and manner stated.	th occurred at the ti nvestigation, in my	ime, date and place, a opinion, death occurre	and due to the cond at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
_ ;	with com.	Σ	29b. Signature and title of certifier	29c. Licens		2	9d. Date signed (Month	n, Day, Year)
	0		On Name and address of acres with a smill trib	D Z	-1/16	3	ANUARY S	12009
	10		30. Name and address of person who completed cause of death (Item 23a) (Type SURLY), MUNDRA MD 300(31. Date filed (Month, Day, Year). 32. Registrar's Signature	S. AF	anover	57	ANNARY S	nort
	Sta Registra		JAN 1 3 2000					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day Louise Elizabeth Cannata 2:00 PM January 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Oak Lodge Senior Home Pasadena Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Min. Months Days Hours 196 01 3307 93 Pennsylvania 06/21/1915 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State Severna Park 1 ∏Yes 2 X No Anne Arundel Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21146 17 Sonneborn Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify: 3 XWidowed 4 ☐ Divorced White 16b. Kind of Business/Industry Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Kitchen Aid 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anthony Casciano Antoinette Meghra 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Keith / Daughter 17 Sonneborn Lane Severna Park, Maryland 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, Maryland MD State Veteran Cem. 01/07/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. nonneou 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Acute Immediate Cause (Final Myorardia disease or condition resulting in death) Due to (or as a consequence of) Hupertenston Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Judgo (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 HInknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Sehile 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) 415 ted Living 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

/Medical Examiner Division of Vital Records, P.O. Box 68760 5 attending physician the ass use for the signed by t has

Physician

/Medical

Examiner

Funeral

Director

or items 23a or 28a-f show

Director

Funeral

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Certification: To

Medical

traumatic event, the Medical Examiner must be notified at

"natural"

Health and Mental Hygiene.

Department of Heal.

Physician

should be filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

page 2 should certificate director, this funeral After 1 or Attending death. after death filled in by 24 hours a Funeral C Hospital

25. Was case referred to medical examiner? 27. Mann of Death 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

(Check only one) 29b. Signature and title of certifier

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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JAN 1 3 2009

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

treine Rand, Suite 204, Catonsville, UD 21228 5. Lep m.D. 700 31. Date filed (Month, Day, Year)

Registrar

completely

To the I within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2009 1 - For State Registrar 00443 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 4.47 AM ELIZABETH CANNON 2009 01 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death UNIVERSITY OF MARNIAMED MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□M 2X F Months Days Hours 212-62-9174 55 April 1, 1953 Maryland Usual Residence of Decedent 10h County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 👿 No Ceci1 Maryland E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 34 West Lewis Shore Road 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 □Yes 2 1 No Specify Specify: 3 Widowed 4 X Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Commercia1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence V. Cannon Mary Elizabeth Walls 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maribeth Cavanaugh/Daughter 106 Woodstock Drive, Chesapeake City, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State January 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State R. A. Ferris & Co., Inc. 4 ☐ Donation 5 ☐ Other (Specify) 2009 West Chester, PA 22. Name and Address of Facility
Hicks Home for Funerals, 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS disease or condition resulting in death) Due to (or as a consequence of): STRIDKOM & HEPATORENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Year Dav 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy

Physician /Medical Examiner

Department of important: If it any injury or o oonce.

Physician

/Medical

Examiner

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Director

Funeral

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d other than "natural", or items 23a or 28a-f show event, the Medical Examirer must be notified at

Pages 1 and 2 should be filed within 72 hours after death with i ment of Health and Mental Hygiene. and if item 27 is marked other than "natural", or items 23a or in yor other traumatic event, the Medical Experiment was ten uny or other traumatic event, the Medical Experiment was ten.

Baltimore, Maryland 21215-0036

or Attending Physician; The law requires that the death certificate be executed burial-trans Division of Vital Records, P.O. Box 68760, physician the attending pl signed by the a cate has been signated by page 2 should b certificate funeral director, this

After t

after death.

24 hours a Hospital

within 2 the

filled in by the

Medical

State

Registrar

29a. Certifier

(Check only one)

Examine Physician/Medical \$ Completed Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No

> 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes

26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No

6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Greene

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2 1

1□Yes

29b. Signature and title of certifier OLUYEMI MY AU1176435018169 MINATI

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMINAT OLLYENG

31. Date filed (Month, Day, Year)

25. Was case referred to medical

32. Registrar's Signature DEMOUR

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death RGAREI **Physician** Month 23,78M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 8049 Veterans Highway Lot 24 Millersville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Vear 1 □ M 2 🗗 F 89 Yrs Director 217 07 0147 08/20/1919 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Directo Millersville 1 ☐ Yes 2 X No Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a 8049 Veterans Highway Lot 24 21108 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 🕱 No Specify: ģ Specify 3 ☐ Widowed 4 ☐ Divorced natural" White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Examiner Maryland Glass 4th 7 Is marked other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Coster (not available) Loretta ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Margaret LeBon / Daughter 8049 Veterans Hwy. Lot 24 Millersville, MD. 21108 item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important; If it any injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park 01/08/2009 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 omenauch 23a. Part 1. Enter the disease, or shock, or heart failure. List on implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between only one cause on each line Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (pisease or frijury that initiated events Physician/Medical Examiner Due to (or as a consequence of) Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ed by the a cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 30. Name and address of person who mpleted cause of death (Item 23a) (Type, Print) TONAPOLIS MO 21401 in 44(1) PFINSE a

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 00445 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Anna M. Clark 9:15 A. /Medical <u>January</u> 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Joseph Richev Hospice Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/21/1919 9. Birthplace (State or Foreign Country)
Maryland **Funeral** Months Days Hours Min 89 Director 216 01 3991 Usual Residence of Decedent 10b. County 10a. State 10c. City Town or Location 28a-f show 10d. Inside City Limits event, the Medical Examiner must be notified Director Baltimore N/A 1 TxYes 2 □ No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 1634 Light Street 21230 U.S.A. Funeral Items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married P. Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. þ Specify: 3 Widowed 4 □ Divorced White "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8th permit. Pages 1 and 2 should be filed be permit. Pages 1 and Mental Hygin Important: If item 27 is marked other 1 any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Bernhard Margaret Lehr မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Clark / Son 1634 Light Street Baltimore, Maryland 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Removal from State 01/10/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Holv Cross Cemeterv 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each list. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-trans Due to (or as a consequence of): Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) ed by the a 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy certificate perform 1 ☐ Yes 2 2 🗆 No ta Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Yes /2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To ō this 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 5 Pending investigation Hospital or Attending 1 Natural death. 2 Accident 1 ☐ Yes 2 ☐ No after death Director: filled in by the Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month Day, Year)

State Registrar nth. Dav.

Year

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year LEVINE L. 10_ COOK JAN. 2009 2:48 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LONG VIEW NURSING HOME MANCHESTER CARROLL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1**√** M 2□ F Months Days Hours Director 220-16-2839 6/22/1924 MARYLAND Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f shov Examiner must be motified at Director MD CARROLL WESTMINSTER 1 ∏Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 341 MARGARET AVE. 21157 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces?
1 XYes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 No Specify: þ Specify: WHITE 3X Widowed 4 □ Divorced "natural" traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) FACTORY WORKER CREAMERY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Menta E. LINDSAY COOK TREVA MYERS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 i - NEPHEW GREGORY WRIGHT 32 GONI TERRACE, WESTMINSTER, MD 21157 Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If It any injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SANDY MOUNT CEM. 1/16/2009 FINKSBURG, MD Signature Funeral Service icensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Part 1. Enter the dise shock, or heart failurse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit and Due to (or as a consequence of): physician s the burial certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes Ö 9 Unknown 9 Unknown 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 | Residence 6 | Other (Specify) Hospital: 1 Tes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 5 Pending within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5170 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PANSURIYA, 349 MALCOLM DR., MD WESTMINSTER. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Celada Raymond J. January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 X M 2 □ F Yrs 11, 074-26-6587 76 July 1932 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes 2 X No North Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 5550 Tuckerman Lane United States 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 DNo 1954

If Yes, Give Year or Dates: 1957 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1954-1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No 1957 Specify. White Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Amada Trabajo Raymond Celada 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Cristina Celada / Daughter 50 West 67th Street, Apt. 5F, New York, New York 10023 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State January 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 14, 2009 4 ☐ Donation 5 Ki Other (Specify) Entombment Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonia disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ursease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Month Year 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Failure to Thrive 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner ner executed Exami

permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trai

Physician

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Funeral

Director

28a-f show

Director

Funeral

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Completed

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7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, It a Medical Examiner must be notified at

72 hours after

d 2 should be filed within than than Mental Hygiene.
7 Is marked other than "r

Baltimore, Maryland 21215-0036

Box 68760.

Division of Vital Records,

/Medical

burial-trans and attending physician for use as the burial Physician/Medical signed by the a d be detached for Completed by should been has page 2 this certificate Be မ Certification:

The law requires that the death certificate be P.0. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

State

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D66066

29d. Date signed (Month, Day, Year) January 12, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Old Georgetown Road, Bethesda, Maryland 20814 Andrew Wong, M.D.

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

1 Natural
2 Accident

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

5 ☐ Pending investigation

6 ☐ Could not be

determined

₹ 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 10:18 AM 1 Chard Januar 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1206 N. Stricker STREE BALTIMORC Social Security Number 6. Sex 1 **X**M 2 ☐ F If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 04/13/1926 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 212 214-24-9828 Months Days Hours Min Director Maryland 82 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is Medical Examinating the retiffied at 1XYes 2 No Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 U.S.A. 1206 N. Stricker Street Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Xes 2 No 1944 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married X Married 3altimore, Maryland 21215-0036 Black 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify. à 1946 Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dry Dock Painter 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Catherine Handy Roland Dix ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 2608 Keyworth Avenue, Baltimore, Maryland Arnita D. Dix / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/14/2009 Baltimore National Baltimore, Maryland ature of Funeral Service icensee 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 4611 Park Heights Ave., Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ongestive disease or condition resulting in death) Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading transmission cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consecuence of) requires that the death certificate be executed Exami burial-trans and Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. signed by the a 1 ☐Yes 2 ☐ No. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Dementa 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed cronary 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy certificate | perform 25. Was c s referred to medical examiner? 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes ospital or Attending Physician: hours after death. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No this Certification: To After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Matural To the Hospital Community within 24 hours after death.

To the Funeral Director: After the Funeral Office of t 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00035363 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore VA Medical Center 10 N. Greene St. Baltimore, MD 21201 Marshallmo andra 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🗎 🛭 🥄 For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 11:40 AM ILLIAM **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** SOMERSET WESTOVEK '02 ASTERN RECTIONAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 08/21/ 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Security Number **Funeral** Days Months 1 1 2 □ F 6250 Director Usual Residence of Decedent 10d. Inside City Limits City, Town or Location 10b. County 10a. State oriant; if item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic avant. Its Modical Exercites must be incilled at Baltimore 1 MYes 2 □ No Director 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 20 by Funeral 600 2 should be filed within 72 hours after death v v and Mental Hygiene. is marked other than "natural", or Items 23s 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S: Armed Forces? 14 Race - American Indian. Black, White, etc. 2 No 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🗹 No Black Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) arber 12 18. Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Dabney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print Mother pe mit. Pages 1 and 2:
Department of Health at
Im. crtant; If item 27 is
an, injury or other trau her 6005 Cer 20b. Place of Disposition (Name of entral 20a. Method of Disposition 3 □Removal from State 1 Burial 2 ☐ Cremation Maryland National Park Sanuary 14 2001 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Swice Lice 22. Name and Address of Facility The Derrick C. Jones Funeral Home, P. A. Heights Ave. Park 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) -IVER CANCER Physician /Medical Dup to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be exect Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wasan autopsy perform 1 Yes 2 No 2 Vital or Attanding Physician: 25. Was case referred to medical examiner?

1 \(\sum \text{Yes} \) 2 \(\sum \text{Mo} \) 26. Place of Death (Check only one) Be 6 Dother (Sharf-IR MARY Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 10 of this Director: After the 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Injury at Work? 27. Manner of Death Certification: Division o 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the ! 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 200 Name and address of person who completed cause of death (Item 23a) (Type, Print) MATHIS MD DAVID EASTERN 32. Registrar's Signature Year, State Registrar

			1 - State of Maryland / D		rtment of F tificate of I		Mental Hy	giene Reg. No. 1	2009	00450
			Decedent's Name (First, Middle, Last)				2. Date of De	eath		3. Time of Death
	Physici /Medio		Najla Dumit				Month Januar	Day	Year 2009	10:15 a.M
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Deat			county of Death	
and the		ш	7007 Longwood Drive		Bethesda				ntgomery	
8	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birti	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Di	ay, rear)	Coui	
			219-27-4798				June 9,	1912	2 Leba	anon
	ylanc how		10a. State 10b. County 10c. City, Town	or Loc	ation				1	10d. Inside City Limits
	Ba-f s	Director	MD Montgomery Bethes	da					ļ	1 □Yes 2 🕱 No
	or 28	Dire	10e. Street and Number		10f. Zip Code			10g. Citize	en of What Cour	ntry?
	s 23a		7007 Longwood Drive		20817				ed State	es
	item item	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (S ın, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14	 Race - Americ Black, White, 	
21215-0036	urs aff	δ	3 ★ Widowed 4 □ Divorced Year or Dates:	1	□Yes 2∏ No	Specify:		s	Specify: Whi	ite
Ŏ-	2 hot	Completed	15. Decedent's Education 16a.	Deced	ent's Usual Occupa	ation		16b. Kind	d of Business/In	dustry
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	ed wi	S	12 4 Te.	ach	er/Homema				Home	
and	be fil ntal H ed otl	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nan	, ,		urname)	
Maryland	should be filed within 72 hours after death with the Maryland and Mental Hyglene. I marked other than "natural", or items 23a or 28a-f show marke event, the Medical Eventine I mathe hearth at unattee event.	٦	Shafik Diap 19a. Informant's Name/Relationship (Type. Print) 19b.	N. 4 - 111 -	A 11 (01 1	Geneviev				
<u>8</u>	nd 2 s Ulth ar 27 is rtrau				g Address (Street a					Code)
ē,	s 1 and 2 soft Health a ltem 27 is		20a. Method of Disposition 20b. Place of	U/_ Dispos	Longwood sition (Name of atory or other place	Dr. Beti	Date P		ation - City or To	own, State
Ë	Page nt: If Iry or		A Dana & La Oreniation 3 La Heritoval north State		atory or other place eaven Cen	i Jan	79,	Silv	er Spri	ng, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventuals by nutfield at once.		21. Signature of Tuneral Service Licensee	1 00	Nome and Address	a of Facility				
<u>n</u>	9 9 5 8 9	1 33	M00982	9	33 Gist A	Ave. Silv	er Spri	ng, M	in 20910	ion Service
			23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	ot ente	r the mode of dyin	g, such as cardiad	or respiratory a	rrest,		Approximate Interval Between
	Physician	6 10	Immediate Cause (Final disease or condition assessed in double and a Alzheimer's							Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of	f):						·
		e	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of)f)·						
١.	uted d ansit	Examiner	Cause, Enter Underlying	.,.						
7	exec an an	Exa	that initiated events ' c Due to (or as a consequence of	f):						
8/60,	ficate be executed physician and s the burial-transit	edical	d							
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gox	leath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy	3 □	Ectopic pregnancy	,		23	d. Date of delive	*
	the a	/sic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 9 Unknown	5 🗆	Other (specify)				Month	Day Year
7.	w requires that the death been signed by the atter should be detached for u		Part II. Other significant conditions contributing to death but not resulting in	the un	derlying cause give	n in Part I	23e Did to	phacen use	contribute to the	ne cause of death?
ecords,	requires een sign nould be	d b	Hypertension, Supraventricular,							pably 4 ☐ Unknown
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r	The law ate has page 2 s	mo	- Congestive heart failure				autop perfo	rmed?	prior to cor death?	npletion of cause of
VITai	an: J	0	25. Was case referred to medical			26. Place of Dear	1 ☐ Yes		1 🗆 Yes	2 □ No
	Physician: r this certific ral director, I	To B	examiner? 1 Yes 2 No Hospital: 1 inpatient 2 ER/Outp	patient	3 □ DOA Othe		ome 5 K Resid		Other (Specifi	v)
n 01	ding Physician: The In. h. After this certificate ha funeral director, page	no.	27. Manner of Death 1 X Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year) Inj	ime of	28c. Injury Work		28d. Describe h			
20	tendi leath. tor: A the fu	cati	2 Accident investigation		M 1 □ Y	′es 2□No				
UIVISION	or At after d Direct in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farr building, etc. (Specify)	m, stree	et, factory, office		28f. Location (S City or Tox	Street and f n, State)	Number or Rura	l Route Number,
_	pital ours a neral I		29a. Certifiler 1 Certifying Physician: To the best of my knowledge,	death	occurred at the tim	o data and slaga	and due to the			
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	f/or inve	estigation, in my op	pinion, death occu	red at the time,	date and pl	lace, and due to	the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier		29c. License	number		29d. Date s	signed (Month, I	Day, Year)
) S. Bourced in)		D39563	3		Janua	ry 5, 2	2009
	3		30. Name and address of person who completed cause of death (Item 23a) (T			100 5	4 -	D 000	17	
			Susan Baruch, M.D. 10215 Fernwood			100 Beth	nesda, M	ய 209 ————	3 T /	
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	ark.	1					i
			7							

4

State Registrar JANE RAPOV 600 NORTH W

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 132009



olfe Street Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 9 2009 Harry Wilson Davis 6:10 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 M 2 F Hours 212 09 6041 Director Baltimore City, Md May 31 1916 Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 ☑ No Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8411 Nunley Drive Apt. D 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1▲Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No þ Specify: 3 X Widowed 4 □ Divorced W II White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) N/A Elementary/Secondary (0-12) 12 Manager/Leadman Black & Decker any Injury or other traumatic event, Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Millard Davis Lola Enicy Spencer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Beech Hill Lane Jacqueline C. Tonti Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gdns. 1/13/09 Baltimore, Maryland 22. Name and Address of Facility
Lassahn Funeral Home Inc Signature of Funeral Service Licensee 7401 Belair Boad Baltimore, Maryland 21236 23a. Part 1. Enter the disease. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CAncer **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): be executed Due to (or as a consequence of): Box 68760. Physician/Medical or Attending Physician; The law requires that the death certificate IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 🔲 Ectopic pregnancy Dav Year 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown Completed 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 □Yes 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Spec Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No မ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled i Lacertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of confice who completed cause of death (Item 33a) (Type, Print) Bmc

State

Registrar

31. Date filed (Month, Day, Year)

3 2009

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andam

Davis

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death P 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 8 **Physician** Month ,200 /Medical 4a. Facility Name (If not institution, give 4b. City, Town, or Location of Death Ac. County of Death Examiner Birthplace (State or Foreign Country) Funeral Days Min. 1 □ M 2 X F Months Hours **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show ?7 is marked other than "natural", or Items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 Ves 2 No timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1st Floor Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ⊟Yes 2 D If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 ☐ Widowed 4 M Divorced Blac Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: If Item 27 is marked other than any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) alto. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other, 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service, License 22. Name and Address of Facility e, or complications that consed the List only one cause on each line. Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the sas , or heart full re. Immedia e Cause (Final disease or condition resulting in death) Cance **Physician** 6 7 34RS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to [or as a consequence of] certificate be executed burial-trai Due to (or as a consequence of) 68760, the attending physician the for use as the burla Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) P.0. 9 Unknown 9 Unknown 交 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed director, page 2 should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has Vital 1 ☐ Yes 2 No 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2**)≦**No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hin 24 hours after deat the Funeral Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Daty signed (Month, Day, Year) 2 29c. License number 290

Registrar

State

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registraris Signature

			1 - State Registrar		State of	Marylar	nd / Depa		nt of Ho te of E		ind Me		giene Reg. 20	09	00454
П	Physici	an	Decedent's Name (First, Mid	die, Last,)						:	Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic	al	HARRY STEPHEN								(D = 15	JAN.	5,	2009	
4	Examin	er	4a. Facility Name (If not institute						, Town, or		t Death		4c. Go	unty of Dear	th
	Funeral		5. Social Security Number	6. Se		7. Age (In yrs.	last birthday)	If Und	TIMOR or 1 Year	If Under 2	24 Hrs.	8. Date of Birt (Month, Day	h	9. Birt	thplace (State or Foreign
Ь	Director		228-52-9329	10	3 M 2□ F	65	Yrs.	Months	Days	Hours	Min.	(Month, Day UNE 23	v. Year) • 194:	Co	DC
	P ,		Usual Residence of Decedent												
	show	7	10a. State 10b. Coun	ty		10c. Ci	ity, Town or Lo	cation							10d. Inside City Limits 1 XYes 2 □ No
	28a-f	ectc	MD 10e. Street and Number			BAI	LTIMORE		ip Code				10- 0''	of What Co	
	with a or	Dir		am.										1 of what Co	ountry?
	ns 23a	Funeral Director	326 S. CASTLE		12. Was Dece	dent Ever in U	J.S. 13.	212 Was Dec	edent of His	spanic Orig	in? (Spec	ify Yes or No-	USA 14.	Race - Ame	erican Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. Item 27 is marked other than "neturel", or Items 23a or 28a-f show other traumatic event, the Medical Evar. It art must be middlied at	by	1 Never Married 2 Married 3 Widowed 4 Divorce	rried	Armed For 1 ⊠ Yes If Yes, Giv Year or Da	rces? 2 No e		If Yes, sp	ecify Cubar 2⊠ No	Specify:	, Puerto R	ican, etc.)	i	Black, Whit	e, etc.
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Z	2 should and Meni is marker sumatic	To	HARRY G. DULES 19a. Informant's Name/Relatio		rpe, Print)		19b. Mailie	na Addre		ETHEI		TER Route Numbe	r City or Ti	own State	Zin Code)
S	and 2 salth ar n 27 is ier trau		SUSAN D. REID	STS	rer rer		2.200.000					OCUST (22508
re,	of Health Item 27 other tra		20a. Method of Disposition			1	Place of Dispo cemetery, crea	sition (N	ame of		Da				Town, State
m m	Pages nent of I ant: If Ita ury or o		1 ☐ Burial 2 🏖 Cremation 1 ☐ Donation 5 ☐ Other			State	ARDI	-	oirioi piaco		1/09/	2009	HANOV	ER, MD)
Baltimore,	permit. Pages 1 ar Department of Hea Importent: if Item any Injury or othe once.		21. Signature of Funeral Service	e Licens	ee //	1			and Address						RL. HM.
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г			23a. Part. Enter the disease shock, or heart failure	or compl st only o	ications that can ne cause on ea	ausod ine dea ago line.	th. Do not ent								Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-	Chr	ONIC	Obs	+Ru	ctive	e Pul	Mac	ARY	DISE	-180	Cristiand Dealin
	Examiner		,		Due to (or as a consec	quence of):					,		-	
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	,	Due to (or as a consec	quence of):	-			·				
W	uted d ansit	mln	cause. Enter Underlying Cause (Disease or injury that initiated events	1											
0,	en an en an irial-tr	Exa	resulting in death) Last		Due to (or as a consec	quence of):								
68760,	icate be executed physicien and s the burial-transit	edical Examiner		-	d										
			IF FEMALE:												
Вох	eath certifi attending I tor use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	2		inth 2 ☐ Feta ant at time of c	al death 3		pregnancy				230	 Date of del Month 	ivery Day Year
P.O.	the de	yslo	1 ☐ Yes 2 █ No 9 ☐ Unknown		9□ Unkno		Jean 5L	Other (:	вр и спу)						
	law requires that the death certif as been signed by the attending 2 should be detached for use a	by Ph	Part II. Other significant cond	tions co	ntributing to de	eath but not res	sulting in the u	nderlying	cause give	n in Part I.		23e. Did to	obacco use	contribute to	the cause of death?
Records,	quires on sign	q pa										1 🗆 Y	'es 2□N	lo 3 Pr	obably 4 Unknown
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Ä	0 - 0	Com											rmed?	death?	completion of cause of
/ita	yelclen: Th is certificate director, pag	Be (25. Was case referred to medie examiner?							26. Place	of Death	(Check only o			
of Vital	S S D	은	1 Yes 2 No			·	ER/Outpatier			4 K Nur		e 5 ☐ Resid			cify)
n C	ting F	lon	27. Manner of Death 1 Natural 5 □ Pend		28a. Date of	h, Day Year)	28b. Time o Injury	f M	28c. Injury Work		i i	3d. Describe h	iow injury o	ccurred	
Division	Attending or death.	Certification:	3 Suicide 6 □ Coul		28e Place	of Injury - At h	nome, farm, str			es 2□N		Rf Location (9	Street and N	lumber or Ri	ıral Route Number.
Β̈́	after after Dire	erti	4 Homicide	mined	buildir	ng, etc. (Speci	ify)	001, 1401	, y, omog			City or Tow			indi Flosto Mander,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After thi completely tilled in by the funeral	edical C	(Check only 2 Medic	ing Phy al Exemi	sicien: To the	asis of examina	owledge, deat ation and/or in	h occurre vestigatio	d at the time n, in my op	e, date and inion, deat	d place, ar h occurred	nd due to the o	cause(s) an	d manner as	stated. to the cause(s)
	thin 2 thin 2 o the	Med	29b. Signature and title of certi		and mann	ier stated.			9c. License						h, Day, Year)
	⊢ 3 ⊢ ŏ		tage, or						_	580	80			٥ ص	*
	2		30. Name and address of person		ompleted caus	e of death (Ite	m 23a) (Type,	Print)					, (<u> </u>	7
	V		ANNE L. VIL		UEVA,	CRNP	25 1	Mais	v St	REET	r. Sr	€ 200	REI	STERS	AM WWOTE
	Sta Registi		31. Date filed (Month, Day, Yea		32. R	egistrar's Sign	ature	1							
	regist		1441127	11 14	1 11 2 26	The state of	Total and								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00455 Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 11:30 A JAN Barbara Ducker 02 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore City 3670 Clarenell Rd. Baltimore | Months | Days | Hours | Min. | Month, Day, Year | 12/15/1927 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🕱 F 220-24-8237 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Be Completed by Funeral Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or Pages 1 and 2 should be filed within 72 hours after death with 3670 Clarenell Rd. 21229 **USA** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Anderson Manlove Ruth Wood Alderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Ducker, Jr. 3670 Clarenell Rd., Baltimore, MD 21229 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 01/08/2009 Gwynoak MD 21207 4 ☐ Donation 5 ☐ Other (Specify) Signature of Juneral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Jam 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) strydire **Physician** 5 YEAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Ten ston 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 □Yes 2 🗷 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier D 26 256 01/05/2009Dan Jury MD 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BICH DUONG, MD 724 Marden Churce Lane Maltimore MO 21228 BICH DUONG, MD /32. Registrar's Signature 31. Date filed (Month, Day, Year) State Barks Registrar

Amend 20b per FH g887 1/13/09 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State	of Marylar		artment of ertificate of					e 2009	00456
	Physici	an	1. Decedent's Name								2. Date of De Month	D	ay Year	3. Time of Death
	/Medic	cal	4a. Facility Name (//		DeSzily			4b. City, Town,	or Location		January		2009 c. County of Dea	07:00 M
	Examir	ner				umber)						4		
	Funeral		5. Social Security N		Hospital 6. Sex	7. Age (In yrs.	last birthday) If Under 1 Year		er 24 Hrs.	8. Date of Bir (Month, Da	th .	Montgo 9. Bi	mery thplace (State or Foreign ountry)
	Director		116-30-9	305	1 🖾 M 2 🗆 F	7		Months Days	s Hours	Min.	Month, Da August 8	y, Year		ountry) gary
	D		Usual Residence of							1	mease o	,	727 1141	
	rylan how		10a. State	10b. County		10c. Ci	ity, Town or L	ocation.						10d. Inside City Limits
	e Ma	cto	Maryland	Montgo	mery			Bethesd						1 □Yes 2X No
	iff th	Director	10e. Street and Nur	mber				10f. Zip Code				10g. C	Citizen of What C	ountry?
	hours after death with the Maryland tural", or items 23a or 28a-f show at Examiner must be notified at	ral	4530_	_Roseda	ale Avenu		-		0814				United S	
	er de	Funeral	11. Marital Status		Armed F		J.S. 13.	. Was Decedent of If Yes, specify Cu	Hispanic C ban, Mexica	Origin? (Spe an, Puerto F	cify Yes or No Rican, etc.))-	14. Race - Am Black, Whi	
36	s aff	by F	1 ☐ Never Marri 3 ☐ Widowed		if Yes, G			1 ☐ Yes 2 🖾 No	Specify	y:			Specify: Wh	ite
Ş	hour	ed		15 Decedent	s Education		16a. Dec	edent's Usual Occ	upation			16b.	Kind of Business	/Industry
215	in 72 n "ne	plet	(Speci	cify only highes	grade completed) (1-4or 5+)	(Give	e kind of work don DO NOT use retir	e during ma ed)	ost of workin	ng			,
213	y with giene	Completed	Elemental y/3eco	nuary (0-12)	2	(1-401 5+)	Gene	eral Mana	ger			l A	Automobi	les
þ	al Hy othe vent,	Be C	17. Father's Name	(First, Middle, L	ast)				18. Moth	her's Name	(First, Middle,	Maide	en Surname)	
<u>/la</u> ı	uld b Ments arked	2		Marti	in DeSz	ily			I	lona	Maith	enyi	i	
ar	2 sho and Is mi		19a. Informant's Na	ame/Relationsh	ip (Type. Print)	-	19b. Mail	ling Address (Stree	et and Num	ber or Rura	l Route Numb	er, City	or Town, State,	Zip Code)
≥ .	and ealth m 27		Judith		// Wife			Rosedale	Aven					
ore	ges 1 t of H if itel or otl		20a. Method of Disp 1 ☐ Burial 2		3 □ Removal from	State Mon	Place of Disp cemetery, cre	oosition (Name of ematory or other pl Cremator:	ace)	Tamian	v 12.		Location - City or	
틆	Emen tant: jury		4 ☐ Donation	5 Other (Sp	ecify)	I	nc.		i	200	8 2009	Beth	nesda, M	aryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, tre Marical Examiner must be muffled at once.		21. Signature of Fu	inerei Service L	icensee	M01532	Ro	22. Name and Add bert A. Pu	ress of Faci mphrey	Funera	1 Home/	Beth	nesda-Chev	y Chase, Inc.
	4 1 2 6 G		Chil	C DO	egan		7.5	557 Wisco	nsin	Ave.,	Bethes	sda,	<u>Maryla</u>	nd 20814-3501
		, l		rt failure. List o	complications that only one cause on	each line.	th. Do not er	nter the mode of d	ying, such a	as cardiac oi	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (disease or conditio resulting in death)	(Final in		psis								1 Day
	/Medical Examiner		, and an address,		20000000	(or as a consec								
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4	uted insit	Ë	Sequentially list cor if any, leading to im cause. Enter Unite Cause (Disease or	rlyir.g injury	-		,)daaaatda						1 Year
85.	icate be executed physician and the burlat-transit	Examiner	that initiated events resulting in death) I	Last		(or as a consec		Dissectio	1115					ı rear
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σŏ	death certific attending pl	¶ an	IF FEMALE: 23b. Was decedent			utcome of pregn		☐ Ectopic pregnar	ncv				23d. Date of de	
- 400	e dea	sici	in the past 12 1 ☐ Yes 2 ☐			gnant at time of		Other (specify)					Month	Day Year
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s,	res th	þ	Part II. Other signif	icant condition	ns contributing to	death but not res	sulting in the i	underlying cause g	iven in Part	t I.				o the cause of death?
MCc.	w requir s teen si s rould I	Completed									10	Yes 4	2 NO 3 F	robably 4 🔼 Unknown
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<u>-2</u> ₹	Physician: this certific al director,	Be	25. Was case reference examiner?		Hospital:			10	Marian.		(Check only o			-
4	Phys rthis ral dir	P	1 ☐ Yes 2 2 2 2 27. Manner of Deatl		112	Inpatient 2	28b. Time	BIIL 3 LI DOA					6 ☐ Other (Spe	ecify)
75	th. : Afer	Ę.	1 Natural	5 Pending	(Mo	nth, Day, Year)	Injury	W	ork? ⊡Yes 2.∐		8d. Describe l	now inju	ury occurred	
- isi	Attend death ctor: / y the f	fica	2 ☐ Accident 3 ☐ Suicide	6 Could no	ot be	e of Injury - At h	ome, farm, si	treet, factory, office			8f. Location /	Street a	and Number or B	ural Route Number,
	after after Dire	Certification:	4 Homicide	determin	build build	ding, etc. <i>(Sp</i> eci	ify)	, - ,			City or Tov	vn, Sta	te)	
3	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely illied in by the funeral director, page 2		29a. Certifier (Check only	1 ☑ Certifying 2 ☐ Medical E	xeminer: On the	basis of examin-	owledge, dea ation and/or i	ath occurred at the investigation, in my	time, date a	and place, a eath occurre	and due to the	cause((s) and manner a	s stated. e to the cause(s)
Ă	Fo the Vithin 2 Fo the I complet	Medical	one) 29b. Signature and	title of certifier	and ma	nner stated.		29c. Licer	nse number			29d. D	ate signed (Mon	th, Day, Year)
1	FSFÖ		1 1 1	12/2	down				3019				11000	
	Mi		30. Name and addr	ess of nerson v	yho completed car	ise of death (Ite	m 23a) (Tvpe			1			1 - 1-	`
	12		Louis Koz		n 8218	Wiccon	cin Ax	zonuo Bo	thesd	a. Ma	rvland	208	314	
	Sta	ite	31. Date filed (Mon	th, Day, Year)	32.	Registrar's Sign	ature /	Kal	21,000					
	Registr	ar	JAI	ATAKA	12 Viene	The fit.	The contract	- चारा						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Edward Elmer Dorsey 5, 2009 0130 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1544 Blue Ball Road Ceci1 E1kton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Months FEB 1, 1938 Maryland Director 212-30-2991 70 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Ceci1 E1kton 10g. Citizen of What Country? 10e Street and Number 10f Zin Code with 6 'natural", or items 23a 1544 Blue Ball Road 21921 United States Funeral death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: ģ 3 Widowed 4 Divorced 72 hours White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Fireman District of Columbia 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clyde Harry Dorsey Gay Stella Reeves 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David R. Dorsey/Brother P.O. Box 231, Childs, MD 21916 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State January 6, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris & Co., Inc. 2009 West Chester, PA 21. Sign Jure of Funeral Service Licensee 22. Name and Address of Facility. Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, aftending physician Physician/Medical as the use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Por in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) I Yes 2 □ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autop performe 2 certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) No Hospital: 1 ☐ Yes 1 Inpatient 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After Certification: Attending 5 Pending investigation 1 Natural 1 Yes 2 No in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Ical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. signed (Month, Day, Year) 29b. Signature and 29c. License number title of certifier 29d. Date

Registrar
DHMH 17 Rev 1/2001

DC

State

0190

28, Name and address of person who completed cause of death (Item 23a) (Type, Pri

32. Redistrar's Signature

31. Date filed (Month, Day, Year)

JAN 1

Amend #25, per MD g887 1/13/09 TT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#18perINF#23a, perPHYS, C887 1/10/09 WS

State of Maryland, Department of Health and Mental Hygiene

Amend PI line b per MD g88/ 1/20/09 TT

Certificate of Death

Reg. No. 2 1 10 1- For Amend PI line b per MD g887 Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** ALBERT DABBAH 17:30PM JANUARY 2009 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE SAINT AGNES N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Mantha Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours 219-76-1547 01/22/1959 Director **FRANCE** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar. Department of Health and Mental Hydene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, the Medical Examinat must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 35 BRYANS MILL WAY 21228 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: \$ WHITE 3 ☐ Widowed 4 ☐ Divorced Specify: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) ELECTRONIC ENGINEER ENGINEERING 18. Mother's Name (First, Middle, Maiden Surname)
Fortunee
FORTUNE 17. Father's Name (First, Middle, Last) Be DAVID DABBAH LICHAA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ESTHER BROWN / SISTER 10523 DORCHESTER WAY, WOODSTOCK, MD 20b. Place of Disposition (Name of ARETNICTON CHT ZUR (ACC) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/11/2009 BALTIMORE, MD BROS., INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death HEMATOMA Mass Immediate Cause (Final **Physician** INTRA CEREBRAL disease or condition resulting in death) ACUTE DAYS /Medical Due to (or as a consequence of) Examiner YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). signed by the attending physician and be detached for use as the buriel-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has pege 2 s autopsy this certificate Vital 1 □Yes 1 ☐Yes 2 ☐ No 2 **5**(No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2XNo Certification: To 1 ☑ npatient 2 ☐ ER/Outpatient 3 ☐ DOA of After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred **Division** To the Hospital or Attending 1X Natural 5 Pending investigation I Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after within 24 hours a

To the Funerel C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) E. Kishny Despike P 20998 01-07-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EVURE, 900 S. CATON AVE, BALTIMORE, MD-21229 VISHNU DEEPIKA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 3 2009 Registrar

BER

ABBAH

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year Anna Juryna Egan 10:00 PM 9, 2009 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Manor Care Potomac Montgomery Potomac 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🖼 F 83 Director 119-18-3710 10/11/1925 NY Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 to No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1654 Woodlands Run 21742-United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 No 2 Specify. Specify: 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Own Home Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed wi if Health and Mental Hygier item 27 is marked other th other traumatic event, The Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nicholas Blahitka Anna Micklisky ್ತ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Mark Egan, Jr./Son 13953 Sanddleview Dr. Gaithersburg, MD 20878-If item 2 or other 3altimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 permit. Page: Department of Important: If any Injury or once. 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Jan 13 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland 2009 Chesapeake Crematory 22. Name and Address of Facility Rapp Funeral & Cremation Services m30382 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** GANGRENE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MIBOLI Secuentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed tthe rosci LEROSIS and burial-tran Due to (or as a consequence of): attending physician Physician/Medical for use as the IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) P.0. the detached 9 Unknown p signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an nas autopsy perforn certificate 2 **M** No 1 □ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **V** No 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Man r of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 ETO 31. Date filed (Month, Day, Year) Registrar's Signature State JAN 1 3 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 9 1 - For State Registrar 00460 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 1/07/2009 10:30 PM Maurice Leroy Eckert /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Crofton Convalescent Center Crofton Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9/19/1917 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□F 91 Director 216-10-3548 MD Usual Residence of Decedent init. Peges 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show Injury or other treumatic event, Ir a Madical Exaction mast be retitled at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7357 Ridgewater Ct., Apt. 203 21060 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White ð 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Machinist Machine Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clinton Eckert Sadie Schwartz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Audrey Inez Eckert / wife 7357 Ridgewater Ct, Apt 203; Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Peges
Department o
Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial | 1/12/2009 Elkridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final aldia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physicien: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed cartificate 1 Yes 2 0 No 1 Yes 2 No the funeral diractor, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Certification; To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 27. Manner of Death
Datural
Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 5 Pending death. 1 Yes 2 No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) completely filled in by 4 ☐ Homicide aftar within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 29c. License number 57028 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #2 Aue Annapolis mD21401 2. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 132009 Registrar parks.

Amend $^{\#2}$ per DVR, $^{\&}$ 19b per FH G887 1/13/09 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 3. Time of Death **Physician JEANNETTE ELMAN** JANUARY 2009 812 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4b. City, 10m., RE C1 7

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

1 O9/05/1915 Examiner SINAL HOSPITAL OF BALTIMORE Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√□ F 93 Director 057-26-2730 ŃΥ Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2**Y**☐ No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1500 BEDFORD AVENUE, #311 21208 USA Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 □ Yes 2 □ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumatic event, the angles. SHOEF ITTER MACY'S 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **GEORGE** LYONS ELVIRA HARTMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21209 RUTH GREENBERG / NIECE 1852 AUTUMN FROST LANE BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH MOSES CEMETERY 4 □ Donation 5 □ Other (Specify) 01/12/2009 PINELAWN, NY 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final **Physician** CHRONIC OBSTRUCTIVE 74ar disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ones a nonsequence of) To the Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 01-08-2009 RES-000 MD 30. Name and address of person who completed cause of death (item 23a) (Type, Print) HOSPITAL OF BALTIMORE. m·D 22. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5 Per FH C887 1/27/09 JH
State of Maryland Department of Health and Mental Hygien 9 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day Physician 8,2009 Richard Wayne Franks January 12:35P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5330 Kelmscot Road Rosedale Balto. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7 7. Age (In yrs. last birthday) **Funeral** Days **X**□ M 2□ F Yrs. Director 62 November 10,1946 Maryland Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

'is marked other then "neturel", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 □Yes 2□No Funeral Director Md. Balto. Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5330 Kelmscot Road 21237 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 XNo 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes X ☐ No Specify: White <u>ک</u> 3 ☐ Widowed 4 🙀 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) <u>Plan Engineer</u> <u>Telephone</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James O. Franks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Pages 1 and 2 st partment of Health an sortent: If Item 27 is r Injury or other trau Son 9113 Bowline Road Nottingham, Md. 21236 Ryan Franks 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Importent: If any Injury or once. 1-12-2009 Meadowridge Elkridge, Md. 21. Signature of Faperal Service Lice 22. Name and Address of Facility Schimunek Funeral Home Nottingham, Md. 21236 9705 Belair Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cardiovascular Arteriosclero disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 Other (specify) To the Funerel Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached I 1 ☐ Yes 2 ☐ No 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performe 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) 27, Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

State

29b. Signature and title of certifier

31. Date filed (Month) Day,

Hospital or Attending Physician: The law requires that the death certificate be executed

death.

Division of Vital Records,

P.O. Box 68760,

Baltimore, Maryland 21215-0036

Registrar DHMH 17 Rev 1/2001 Trimble H: 11 CT. Lutherville, Md

and manner stated.

MD

Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

ello

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician 2 490 Rowland Fontz anuav /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington haltimore Medical Glen Social Security Number 7. Age (In yrs. last birthday) Year | If Under 24 H Birthplace (State or Foreign Country) **Funeral** Year) 1⊠M 2□F Months Days Hours Yrs Director 220-12-6414 Jan. 82 14,1926 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 200 Ken-Mar Ave. 21122 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: white 2 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Horologist clock maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance and Mental F William ဂ Edward Font 2 Edith Walther 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2 a Department of Health a Important: If item 27 is any injury or other trau once. Diane Shoe daughter 200 Ken-Mar Ave. Pasadena MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc. 1/12/2009 Baltimore Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Stallings Funeral Home P.A. 3111 Mountain Road Pasadena MD21122 23a. Part 1. Enter the dilease, or complicat and that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart faill ite. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 Physician NIV /Medical Due to (or as a consequence of) Examiner ulmonar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed attending physician and for use as the burlal-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. I ned by the a 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I funeral director, page 2 s autopsy performe 2 1 No 2 1 No 1 □ Yes 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Man or of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) anuery 10 30. Name and address of person who completed cause of death (kem 23a) (Type, Print)

TO NIGO F Wicks W SOL SOL SOL DISPITED DVIVE, Plan Burnie 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Denus A. park

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10e, perFH, G887, 1/13/09, WS
State of Maryland / Department of Health and Mental Hygiene

			For State	Glate Of Mary		partment of I		iu wentai ny	giene		
			Registrar 1. Decedent's Name (First, Middle, La	et)		ertificate of	Death	2. Date of De	Reg. No.	009	0.04.65
	Physicia	an	Martha G. Fi					Month Jan.	8 Day	2009 Year	1:45 A M
and the same	/Medic		4a. Facility Name (If not institution, given			4b. City, Town, c	or Location of D			County of Death	1.45 11
1	Examin		The Maples of To	owson		Т	owson			Balti	more
	Funeral		Social Security Number 6. S	DM OFFE	rs. last birthd	y) If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, D	ay, Year)	9. Birthp Coun	lace (State or Foreign try)
	Director		215-22-1786 Usual Residence of Decedent	81 81	Yrs			Nov.	17 19	27 MD	
land	Mo #		10a. State 10b. County	10c.	City, Town or	Location				11	Od. Inside City Limits
Man	a-f sh	ctor	MD Baltimo	ore	Towson						1 □Yes 2 □ No
th the	or 28	Dire	10e. Street and Number 7925 7910 York Rd.			10f. Zip Code			10g. Citiz	en of What Coun	try?
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er de	le me	-un-	11. Marital Status1 ☐ Never Married2 ☐ Married	12. Was Decedent Ever in Armed Forces?	1 U.S. 1	Was Decedent of I If Yes, specify Cub	Hispanic Origir Jan, Mexican, F	n? (Specify Yes or N Puerto Rican, etc.)	0- 1	 Race - Americ Black, White, e 	
21215-0036 d within 72 hours aft	p	þ	3 X Widowed 4 ☐ Divorced	1 □Yes 2 ▼No If Yes, Give Year or Dates:		1 □Yes 2∏No	Specify:		Ι.	Specify:	white
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21. Thin 7	ne. Med	agr.	Elementary/Secondary (0-12)	College (1-4or 5+)	life	e. DO NOT use retire	d)	i working		1. 1	
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Maryland d 2 should be file	ed of	Be C	17. Father's Name (First, Middle, Last	_					e, maiden c	•	
aryi should	mark mark	은	Bruno 19a. Informant's Name/Relationship	Gatto Type. Print)	19b. M	ailing Address (Street		ephine or Rural Route Numi	ber, City or	Vazzana Town, State, Zip	
Nd 2	alth a 27 is er trau		Richard J. Muffol	letto/cousin	112	4 Chatterl	eigh C	ir., Tows	on, M	D 21286	,
altimore, mit. Pages 1 ar	of He		20a. Method of Disposition		b. Place of Dis	position (Name of rematory or other pla	ce)	Date	20c. Loc	cation - City or To	wn, State
E Bag	ant: h		1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia		tlanti	c Cremator	y 1,	/9/09	Glen	Burnie,	MD
Ball permit	Department of Health and Mental Hygene. Important: If them 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Experiest must be notified at once.		21. Signature of Funeral Service Light	Say		22. Name and Addre Lemmon Fu 10 W. Pado	meral l	Home of Da	ulane	y Valley D 21093	, Inc.
			23a. Part 1. Enter the disease, or com shock, or hear failure. List only	plications to caused the d				W. 100 P.			Approximate Interval Between
	nysician		Immediate Cause Final disease or condition resulting in the second secon	100	relia	Int	aret	100			Onset and Death
	/Medical Examiner		resulting in death	Due (or as a cons	sequence of):	1 1.	1:00	1.	A :	24	em kho wer
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J. 3	nsit	i i	Cause (Disease or injury	HUDEN	Fein.	5.10 W					=
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rtifica	ng ph as th		IF FEMALE:	V							
Box eath cer	ittendi or use	ian/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	etal death	3 ☐ Ectopic pregnanc	су		2	3d. Date of delive Month	ry Day Year
કુક	the a	Physician/M	1 ☐ Yes 2 No 9 ☐ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown	of death	5 ☐ Other (specify) _				NOTE:	ouy rour
r that th	ned by		Part II. Other significant conditions	contributing to death but not	resulting in the	underlying cause giv	ven in Part I.	23e. Did	tobacco us	se contribute to th	e cause of death?
rds guires	an sig	ed by	Dementia					1□	Yes 2	No 3□ Prob	ably 4 ☐ Unknown
aw re	ss bee	Completed	Bipolar of	isorder				24a. Was	an	24b. Were autor	sy findings available
T P	ate hi	ē	Bepress 10h						ormed? 2 No	death? 1 ☐ Yes	npletion of cause of
/ita cian:	ertific actor,	Be (25. Was case referred to medical examiner?					Death (Check only			
Division of Vital Records, I or Attending Physician; The law requires ti	this certificate has al director, page 2 a		1 Yes 2 No	Hospital: 1 Inpatient 2			4 LI Nursi	ing Home 5 Res			ALL
On ding	h. After funer	tion	27. Manner of Death 1 Natural 5 Pending investigatio	28a. Date of Injury (Month, Day, Year	28b. Time (njur	y Wor	rya⊺ *k?]Yes 2.∐No	28d. Describe	how injury	occurred	
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	s after	Certification: To	4 ☐ Homicide determined	building, etc. (Sp	ecify)			City or To	wn, State)		,
e Hospit	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (29a. Certifier (Check only one)	nysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, de nination and/o	eath occurred at the ti	ime, date and popinion, death	place, and due to the occurred at the time	e cause(s) , date and	and manner as st place, and due to	ated. the cause(s)
To th	withir To th сотр	Me	29b. Signature and title of certifier	- MD	ı	29c. Licens	se number 8	5	29d. Date	signed (Month, L	Day, Year)
	10		30. Name and address of person who	completed cause of death (Item 23a) (Tvr				' [0/0/	
	10		Bushra Al-Azzawi	, M.D. 91	03 Fra	nklin Squa	are Dr.	, Suite 3	01, B	alto., M	ID 21237
	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 3 2009	32. Registrar's Si	nature A	the I					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 7 200 C) Month JANHARY 8:09AM **Physician** BELLE FENSTERWALD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A BALTIMORE KESWICK MULTICARE CENTER 8. Date of Birth (Month, Day, Year) 12/17/1925 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗶 F 83 214-20-9392 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21208 USA 3103 HATTON ROAD death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Š 3 X Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Medical 16b. Kind of Business/Industry alth and Mental Hygiene.

27 is marked other than "i Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be å BRAGER NEHEMIAH ALTMAN HILDA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is
any Injury or other trau GENE KLEIN / DAUGHTER 3103 HATTON ROAD, BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW 01/11/2009 REISTERSTOWN MD 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ende stage desnemes 15 **Physician** ears /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): physician and s the burial-transit death certificate be executed Examin Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregna 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year for 4☐Pregnant at time of death 5 Other (specify) P.0. ate has been signed by the page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1□ Yes 2 W/No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No Medical Certification: To 27. Mann f Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ieral Director; After filled in by the funer (Month, Day Year) Injury 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 1 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

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State Registrar

MOUREGIR M. BABELLE 31. Date filed (Month, Day, Year)

3 2009

29b. Signature and title of certifier

12 Trabelle

Registrar's Signature

Gregar or)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

700 W 40 %

29c. License number

D13657

Street, Baltiniste, Ma 21211

29d. Date signed (Month, Day, Year)

Vanuary 7, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day ar man 10 2009 Januar /Medical Facility Name (If not institution, give street and number) Examiner 4c. County of Death ndalls Center HOSpital 25 a TIMOVE DWG If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** 7. Age (In yrs. last birthday) Days **X**□ M 2□ F 080-18-7738 82 Yrs. Director 04/6/1926 NY Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov r items 23a or 28a-f shov alter nast be retified at Director MD BALTIMORE OWINGS MILLS 1 ☐ Yes 2 Y☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3440 ASSOCIATED WAY APT. 102 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Exprin 1 MYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes Z□No WHITE Completed by Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HYMAN FELDMAN **ESTHER** UNKNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TERRY FELDMAN/WIFE 3440 ASSOCIATED WAY,APT.102 OWINGS MILLS,MD 21117 20b. Place of Disposition (Name of SWINICHER WOLTINER BENEVOLENT SOCIETY 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/11/2009 BALTIMORE, MD of Funeral Service Lo 22. Name and Address of Facility SOL LEVINSON & BROS., INC. <u>8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208</u> 23a. Part 1. Enter the disease, or complications or heart failure. List only on ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ibVascu disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3

Ectopic pregnancy Month Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s peen s 24b. Were autopsy findings available prior to completion of cause of death? has page 2 s 24a. Was an autopsy his certificate h I director, page 1 □Yes 2 No 2 **V**No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Division 1 Natural 2 Accident 5 Pending investigation death. nours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 6 To the Hospitai within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifie

State Registrar Ca

at

32. Registrar's Signature

MO

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 200°9 **Physician** 1030 A Griffith Lerov Ε. Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 9. Birthplace (State or Foreign Country) Rosedale 6. Sex \ 1 \(\overline{X}\)M 2 \(\overline{\text{F}}\) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 216-80-6242 48 August 26, Maryland Director 1960 Usual Residence of Decedent 10b. County 10c. City, Town or Location artment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, Ite Modical Examinat must be notified at 10a. State 10d. Inside City Limits 1 ☐ Yes 2 XNo Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1524 Alconbury Road 21221 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 years Admitting Office Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leroy E. Griffith Sr. Barbara Jean McCaulev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any Injury or other traum Leroy E. Griffith Sr. Father 9701 Harford Road, Parkville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Memorial 16, 2009 4 ☐ Donation 5 ☐ Other (Specify) Middle River, MD. Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) signed by the sid be detached f P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ No No 1 ☐ Yes 3 Probably 4 Unknown page 2 should Completed peen 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performed? Yes 2 No certificate Division of Vital 1 ☐ Yes 1 ☐Yes 2 ☐ No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 □ DOA ၉ After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural
2 Accident Injury death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JAN 132009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#1perPHYS,#5perFH,G887,1/21/09,WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Kadaba 2. Date of Death N. Gopalakrishnan Month 2009 Kadaba Copalakrishnan January 8:50 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 1 M 2 □ F Months Days Hours Min 90 -88-0726 September 17, 1918 India Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8310 Larkmeade Terrace 20854 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 XX If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Specify: Asian-Indian 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Computer Sciences College (1-4or 5+) Elementary/Secondary (0-12) Scientist Corporation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kadaba Narayana Iyengar Vedamma Iyengar 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Godha G. Prasad / Daughter 11012 Larkmeade Lane Potomac, Maryland 20854 20a. Method of Disposition
1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 10, Januarv 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 2009 Bethesda, Maryland 21. Signature of Funeral Service Licenset 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.
7557 Wisconsin Avenue Bethesda, Maryland 20814 Barrilon M01546 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hyperkalemia 2 Days disease or condition resulting in death) Due to (or as a consequence of): Chronic Renal Failure Years Sequentially list conditions, if any leading Limme distances. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Diabetes Mellitus Years Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Coronary Artery Disease, Hypertension, 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 🗍 Unknown Congestive Heart Failure, Anemia, 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □ Yes 2 🖾 No Gastro Intestinal Bleeding 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2⊠No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be

Examiner law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, After this Hospital or Attending

attending physician and for use as the burial-transit signed by the a d be detached f is certificate has been si director, page 2 should t funeral (within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

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permit. Pages 1 and 2 st Department of Health and Important; If item 27 Is n any injury or other traun once.

Physician

/Medical

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Completed

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Certification: To

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only

traumatic event, the Medical Examiner must be notified at

should be filed within 72 hours after death with and Mental Hygiene.

altimore, Maryland 21215-0036

State

Medical 29b. Signature and title of certifier

determined

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D53367

January 8, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shyamsundar Rajan, M.D. 9801 Georgia Avenue Suite 117 Silver Spring, Maryland 20902

31. Date filed (Month, Day, Year) JAN 132009 32 Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 00470 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ნშ,2009 January Physician 7:00 A.M Bertha Graham /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Riverview Care Center Essex 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV/, 1911 7. Age (In yrs. last birthday 5. Social Security Number 6. Sex **Funeral** Maryland Days Hours 1 □ M 2 🖺 F 97 220-12-6686 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Exactions must be notified at Y□Yes 2□No Directo Baltimore City Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 U.S.A. 312 Gusryan Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status Specify: White 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade com grade completed) College (1-4or 5+) Elementary/Secondary (0-12) ATCO Cleaners Presser 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Kern Nicholas Rebel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charles Quigley/Grandson 9 Beach Drive Baltimore, Maryland 21222 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemeteryl-13-2009| Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 2000 00 5 ki Funeral Home, P.A. 21. Signature of Funeral Service Licepsee 1201 Dundalk Avenue Baltimore, Md. Foliat 200 0 Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or a la consequence of) Examiner The law requires that the death certificate be executed anding physician and use as the burial-transit MXIE resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical attending properties for use as IF FEMALE: yes, outcome of pregnancy
□ Live birth 2 □ Fetal death
□ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) signed by the a d be detached fo □Yes 2□No Ö 9 Unknown 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag 2 XNo 2 No 1 □ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 X No P 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and M.D. January 10, 2009 55171 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Sebastian K. John, M.D. 3023 Eastern Avenue Baltimore, Md. 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2009 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 12:15 p ^M January Tad Hollamon, Jr. Vassie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Catonsville Baltimore Summit Park Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. 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Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of Birth | 8. Date of B 9. Birthplace (State or Foreign Country) Maryland 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1**X** M 2□ F 70 219-26-7440 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a, State 10b. County ral", or items 23a or 28a-f show Baltimore Catonsville 1 ☐ Yes 2 X No Director MD 10f. Zip Code **21228** 10g. Citizen of What Country? Street and Number Pages 1 and 2 should be filed within 72 hours after death with tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 3 and or other than "natural", or items 1 and 1 20 Dungarrie Road USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1xYes 2 No If Yes, Give Year or Dates:1956-59 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: White ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Elementary/Secondary (0-12) College (1-4or 5+) Defense 5+ Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be В. Pollock Vassie Tad Hollamon, Sr. Hanna ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20 Dungarrie Road, Catonsville, MD Carol S. Hollamon - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of Important: If it any Injury or conce. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 01/10/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Services are H Cremation Society of Maryland, Inc. Williams 299 Frederick Road, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a conse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Physician/Medical Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>چ</u> 3 Probably 4 Unknown 1 🗌 Yes been si should t Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b irector, page 2 sl autopsy performe 2 No 1 ☐Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1∐ Yes 2 No No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manne Teat 28b. Time of 28d. Describe how injury occurred After 1 atural 2 Accident 5 Pending investigation 1 ☐ Yes 2 🗆 No within 24 hours after death To the Funeral Director: completely filled in by the 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical one and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of dertifie

State

Registrar

Name and address of person

31. Date filed (Month

th, Day, Year)
JAN 13 2009

DHMH 17 Rev 1/2001

ORIGINAL

no completed cause of death (Item 23a) (Type, Print)

Amend #9 per FH g887 1/13/09 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 12, 2009 5:47 AM Edith M. Harvey 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death N/A Johns Hopkins Bayview Medical Center Baltimore 9. Birthplace (State or Foreign Country) VA 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Days VA 1 □ M 2 🖾 F 83 Yrs 1925 219-60-8093 Feb 14. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐Yes 2 No Dundalk Maryland Baltimore 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 **USA** 1906 Barry Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 □Yes 2√∑No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Child Care Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Susie Mae UNK. William Harvey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Yvonne Maddox, Friend 1906 Barry Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Metro Crematory Inc. 01/13/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cremation Stellety Of Maryland, Inc. 21. Signature of Funeral Service Licensee 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor Momas 23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death teve Immediate Cause (Final disease or condition resulting in death) Due to (or as a comequence of): 22 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 **X**No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature, and title of certifier

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To the Hospital o within 24 hours aft To the Funeral Di completely filled in

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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31. Date filed (Month, Day, Year)

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OSLER DRIVE TOWSON, MARYLAND

D 75.01 Registrar's Signature

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** January 11,2009 Marian E. Hook /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Balto. 5007 Kenwood Avenue Fullerton 9. Birthplace (State or Foreign Country)
25,1929 Maryland If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Date of Birth (Month, Day) **Funeral** Days Hours 1 □ M 2**X** F 79 Director January 216-24-2511 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner in ust be notified at once. 1 ☐ Yes 2X No Funeral Director Md. Balto. Fullerton 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 5007 Kenwood Avenue 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 W hite 1 ☐ Yes 🏋 ☐ No Specify: Completed by 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Envelope Company Envelope Machine Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grace E. McDonald Henry J. Spangler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5007 Kenwood Avenue Fullerton, Md. 21206

of Disnosition (Name of Date 20c. Location - City or Town, State Barbara Spangler Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-12-2009 Bayview Balto.city 21. Signature of Faneral Service License 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Tic Candio Vascular **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 ☐ Other (specify) 2 □ No 1 ☐ Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Ccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of pers completed cause of death (Item 23a) (Type, Print) ble 4:11 CT. Luthonville, Md 21093 670 ello MA 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

9-00 191 Villiam Harmon, Ji	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State Legible. 2009 004 Reg. No.
Physician/ ledical Examine	1. Decedent's Name (First, Middle,Last) William T. Harmon, Jr. 2. Date of Death Month Day January 7, 2009 3. Time of Death 1514 hrs
*	4a. Facility Name (if not institution, give street and number) University Hospital 4b. City, Town, or Location of Death Baltimore 4c. County of Death N/A
Funeral Director	5. Social Security Number 217-83-4028 1 X M 2 F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 1 Year 1 Inder 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 1 Age (In yrs. last birthday) 1 Year 1 Inder 24Hrs. 8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State or Foreign Country) MD 1 Year 1 Inder 24Hrs. 8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State or Foreign Country) MD 1 Year 1 Inder 24Hrs. 1 Year 1 Inder 24Hrs. 1 Year 1 Inder 24Hrs. 1 Year 1 Inder 24Hrs. 1 Year 1 Inder 24Hrs. 1 Year 1 Inder 24Hrs. 1 Year 1 Inder 24Hrs. 1 Year 1 Inder 24Hrs. 1 Year 1 Inder 24Hrs. 1 Year 1 Inder 24Hrs. 2 Year 1 Inder 24Hrs. 2 Year 1 Inder 24Hrs. 2 Year 1 Inder 24Hrs. 2 Year 1 Inder 24Hrs. 2 Year 2
Maryland 28a-f show any datonce.	Usual Residence of Decedent 10a. State
in the Maryland 13a or 28a-f sh notified at once	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 United States
or items 23:	11. Marital Status 12. Was Decedent Ever in U.S. 1X Never Married 2 Married 3 Widowed 4 Divorced of Yes, Give Year or Year or Year or Year or Year or Year or Year or Year or Year or Year or Year or Year or Year
72 hours natural Exam	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A 16b. Kind of Business/Industry
121 Id be fi fental narked event,	17. Father's Name (First, Middle, Last) William T. Harmon, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Chentell R. Ensev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MD 21 nd 2 should ulth and Me m 27 is ma aumatic ex	William T. Harmon, Sr. Father 83 Colony Hill Court, Baltimore, MD 21227
Baltimore, MD 2 spernit. Pages I and 2 shou Oepartment of Health and Minportant: If item 27 is uniquery or other traumatic	Burial 2 XCremation 3 Removal from State Atlantic Crematory 01-11-2009 Glen Burnie, MD
Baltir Permit. P Departme injury or	21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 232. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva
Medical xaminer	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sudden unexplained neonatal death Due to (or as a consequence of):
j	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause
ecuted and sand transit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
2. la a c	X_{UNPENDED} X_{AMENDED} $\#1$ as noted, 23a,2/,28a-t,perME G890 4/29/09 TT
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 horard after death. To the Functual Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring and Contributed by Divisional Model.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown
P.O. E res that the d signed by the be detached	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown
Records, F The law requires ficate has been sign, page 2 should be	24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
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Division of Vistorial Division of Vistorial Director: After this filled in by the funeral director: After this filled in by the funeral director:	27. Manner of Death 1 Natural 5 Pending Investigation 28a. Date of Injury (Month, Day, Year) 4 Coldent Investigation Fd 1/6/2009 Fd 2:54 am 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 X No unk
Divisior Hospital or Attend 24 hours after death Funeral Director: stely filled in by the	3 Suicide 6 X Could not be determined Homicide Suicide 6 X Could not be determined Homicide Suicide 6 X Could not be determined Homicide Suicide 6 X Could not be determined Homicide Specify) See. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 83 Colony Hill Ct Halethorpe, MD
To the Hos within 24 h To the Fun completely	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
# # 8 B	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 8, 2009
	30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
Stat Registra	31. Date filed (Month, Day, Year) 32 Registrar's Signature JAN 1.3 2009 Person L. Januar L.
DHMH 17 Rev 1/200 OCME 2006	ORIGINAL ORIGINAL

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	Funeral Director		5. Social Security 213–28–		6. Sex 1 X M 2□ F		e (In yrs. k 79	ast birthday) Yrs.	If Under Months	1 Year Days	If Und Hours	er 24 Hrs. Min.	8. Date of Bi (Month, D				place (State on htry) vland	r Foreign
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ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, I'm Machen Engring must be writted at 10a. State Director 10e. Street and Number Completed by Funeral 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be ပ္ 19a. Informant's Name/Relationship (Type. Print) permit. Pages Department of Important: If it any injury or o 21. Signature of Funeral Service Licenses 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if an cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed and physician a s the burial-t Physician/Medical attending p as IF FEMALE: 23b. Was decedent pregnant in the past 12 months? by the a certificate has been signed l rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by funeral director, Be 25. Was case referred to medical 1∐ Yes Medical Certification: To After this 27. Manner of De th To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A death. 2 Accident the 1 3 ☐ Suicide completely filled in by 4 Homicide 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) EW NED RESIDEN ひして 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 (AZER) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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			For State	State of Maryland	I / Department of Health and N Certificate of Death	lental Hygien	711119	00478
	Physicia		1. Decedent's Name (First, Middle, La	A. Hall	Commodite of Death	2. Date of Death	Pay 2 Year 2 0 0 9	3. Time of Death
4	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)	4b. City, Town, or Location of Death	Ce Ja	c. County of Deeth	
	Funeral Director		5. Social Security Number 6. S 213-32-5760 Usual Residence of Decedent	ex $\left[\begin{array}{c c} \text{Age (In yrs. la} \\ \text{M} & 2 \square \text{ F} \end{array}\right]$	st birthday) Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea April 5, 1	9. Pirthpla 936 Ma	ace (State or Foreign
	Maryland a-f show	tor	10a. State 10b. County	A 10c. City,	Town or Location		100	d. Inside City Limits 1 Yes 2 □ No
	th with the 23a or 28a	Funeral Director	10e. Street and Number Rigo	15 Ave.	10f. Zip Code 2/2/6	10g. C	Citizen of What Countr	y?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ᠓ No If Yes, Give Year or Dates:	 13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerton 1 □ Yes 2 ☑ No Specify: 	pecify Yes or No- Rican, etc.)	14. Race - America Black, White, etc	n Indian, c.
21215-0036	hin 72 hour e. an "natural Medical E.	Completed I	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)		Kind of Business/Indu	ustry
	be filed with tal Hygiene d other the event, the	Be	17. Father's Name (First, Middle, Last,	0	Laborer 18. Mother's Nam	e (First, Middle, Maide	I STU	Harbor
Maryland	d 2 should th and Mer 7 is marke traumatic	To	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Ru	er Ta ral Route Number, City	or Town, State, Zip (Code)
Baltimore,	Pages 1 and 2 nent of Health int: if Item 27 i iry or other tra		20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specif	Removal from State	ace of Disposition (Name of metery, crematory or other place)	Date 20c.	Location - City or Tow	m, State
Baltii	permit. Page Department Important: II any Injury o	Ы	21. Signature of Funeral Service Licer		2. Name and Address of Facility 0. Seph L. KUSS F	uneral H	tome P.A.	16
W. W.	Physician		short, or heart frure. List only Immediate Cause (Final disease or condition	plic lions that lused the death. one cause on each line.	Do not enter the mode of dying, such as cardiac	or respiratory arrest,	, 1	Approximate Interval Between Onset and Death
-	/Medical Examiner	16	resulting in death) Sequentially list conditions,	b	·		0	
,	executed n and ial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c				
68760,	rificate be ng physicia as the buri	ical		d				
.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 ☐ Ectopic pregnancy		23d. Date of delivery Month D	y Day Year
rds, P.	quires that en signed b uld be deta	by	Part II. Other significant conditions of	contributing to death but not resul	ting in the underlying cause given in Part I.		o use contribute to the 2 ☑ No 3 ☐ Proba	e cause of death?
Vital Records,	The law re ate has bee page 2 sho	Completed				24a. Was an autopsy performed?	prior to com death?	sy findings available pletion of cause of
Vita	ding Physician: The I h. After this certificate h. funeral director, page	Be	25. Was case referred to medical examiner?	Hospital:	Other:	th (Check only one)		
n of	ng Physter this neral di	n: To	27. Manner of Death		ER/Outpatient 3 DOA Outer 4 Nursing H	ome 5 ☐ Residence 28d. Describe how inj)
Division of	or Attendir ter death. irector: Af n by the fur	Certification: To	1/Sonatural 5	1	M 1 ☐ Yes 2 ☐ No	28f. Location (Street a	and Number or Rural ite)	Route Number,
_	Hospital of 24 hours a Funeral Detely filled i	Medical Ce	29a. Certifier (Check only one) 29a. Certifying Pl	nysician: To the best of my know niner: On the basis of examinati and manner stated.	vledge, death occurred at the time, date and place ion and/or investigation, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as stand place, and due to t	ated. the cause(s)
	To the within To the comple	Mec	29b. Signature and title of certifier	Mely	29c. License number	29d. E	Date signed (Month, b	ay, Year)
5	2 T				23a) (Type, Print) DIVISION ST /	BACT 11	MORE M	102/21
	Sta Registr		31. Date filed (Month, Day, Year) JAN 13 2003	32. Registrar's Signati	factol			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 10, 2009 **Physician** 9:50 Ruth Humme 1 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Brightview Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Oct 25, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days 1 ☐ M 2 👿 F 89 218-07-6554 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10h County 10c. City, Town or Location al", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21236 USA 8100 Rossville Blvd. permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Eventure ponce. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 21XNo Baltimore, Maryland 21215-0036 white 3 ☑ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Architectural Firm 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Stanek John Benjamin Franz ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 714 Colorado Avenue; Baltimore, MD 21210 Patricia Sullivan / daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Towson, MD 1050 York Road Hilltop Service Corp. 1/12/09 21. Signature of Funeral 22. Name and Address of Facility MD 21204 Ruck Towson Funeral Home Towson, 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** ZHEIMER'S disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ûnknown DIABETES 24b. Were autopsy findings available prior to completion of cause of death? HYPERLIPIDEMIA 24a. Was an certificate has l rector, page 2 s autopsy performed HYPERTENSION 1 ☐Yes 2 ☐ No 1 □Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D28987 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 124 BALTE, MD RAVEN BLUD 5601 LOCH SPERLING, M.D. 31. Date filed (Month, Day, Year). 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Pay AMOTARY 2889 **Physician** 11:33P M RUTH BAUR HERTSLET /Medical 4c. County of Death Baltimore 4a. Facility.Name (If not institution, give street and number)
Saint Joseph Medical Center 4b. City, Town, or Location of Death Examiner OWSON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5 Social Security Number 6. Sex **Funeral** Days Months 1 □ M 2 🔽 F Feb 14, 1916 Connecticut Director 123-05-7072 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10h County 28a-f show ral", or items 23a or 28a-f show 1 ☐ Yes 2X No Maryland Baltimore County Towson Director 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number USA 21286 704 Thornwood Court Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 X No Baltimore, Maryland 21215-0036 Specify If Yes, Give Year or Dates: Specify: Completed by White 3 Widowed 4 Divorced 12 Shours - thand Mental Hygiene.
27 Is marked other than "natural". "natural" 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Residence yrs Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude Eva Shaw Baur Frederick ဥ 19a. Informant's Name/Relationship (Type. Print) (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 715 Stevenson Lane, Baltimore, Maryland 21286 Byron B. Hertslet, Esq. 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland Dul Valley Mem Grdns 1/16/2009 21. Signature of Foreral Service Lightsee

Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASYSTOLE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): CHRONIC DYSRHYTHMIA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No should I 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☑No 24a. Was an autopsy performed? Yes 2 No s certificate has l irector, page 2 s 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 🗆 Inpatient 1 ☐ Yes this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. filled in by the f 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion death occurred. within 24 hours a

To the Funeral C

completely filled 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific D46356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON, MARYLAND DRIVE 21204 TABASSI, M. D. 7601 OSL KHASROW 32. Registrar's agnature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2009Certificate of Death 2. Date of Death 3. Time of Death Month Year 11.53 PM HAMMEL 2000 04

1. Decedent's Name (First, Middle, Last) **Physician** NORMA /Medical 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL HARBOR 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F 79 214 24 8581 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland I Hygiene. 10a State 10b County show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Model Event Performer, and be nottled at Anne Arundel Director Maryland 10e. Street and Number 8 Chester Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🕱 No 1 Tes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 12th 17. Father's Name (First, Middle, Last) John Hohman ပ 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other trau once. Russell Hammel Jr./son 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

4b. City, Town, or Location of Death 4c. County of Death Baltimore If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 08/14/1929 Maryland 10c. City, Town or Location 10d. inside City Limits Glen Burnie 1 Tyes 2 X No 10f. Zip Code 10g. Citizen of What Country? 21060 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) Eleanore (not avavilable) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 833 Sunnyfield Lane Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State

MD State Veteran Cem. 01/09/2009 Crownsville, Maryland 2. Name and Address of Facility Gonce Funeral Service, P.A. Manucounty 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.

Sephicaenic neumonia Due to (or as a consequence of): muchiorsan Due to for as a consequence off. Due to (or as a consequence of):

Shock

ii any, leading to immediale cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tes

23d. Date of delivery

Day

Year

Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a, Was an autopsy performe 1 ☐Yes 2 MNo

25. Was case referred to medical examiner? 1 Yes 2 10 No

Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

27. Mannet of Death 1 Natural 5 Pending 2 Accident

28a. Date of Injury (Month, Day, Year) investigation

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

26. Place of Death (Check only one)

29b. Signature and title of certifier

29c. License number KES 0001 29d. Date signed (Month, Day, Year) 30 , 04, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001, S Hanover St. Harbor HSp. tell, Balkmar, MD, 21225 base

State Registrar 31. Date filed (Month, Day, Year)



DHMH 17 Rev 1/2001

Physician

/Medical

Examiner

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certificate

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ne Hospital or Attending Pi n 24 hours after death, ne Funeral Director: After ti pletely filled in by the funeral

within 24

After this funeral d

law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

Examiner

Physician/Medical

≥

Completed

Be

Certification: To

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien U 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day LOUISE HAUSER JAN 2009 11:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SYKESVILLE SERRA DRIVE UNITO CARROLL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1□M 2**X**F Hours Year) 89 214 01 1051 Director 16 1919 MARYLAND Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show CARROLL SYKESVILLE 1 ☐ Yes 2 No Funeral Director mn 10e. Street and Number 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be USA 2002 RUNY SERRA DRIVE UNITO 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: WHITE 3 Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OMEMAKER OWN HOME is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HEFFINER LEROY LULA BELLE ပ SMITH 19a. Informant's Name/Rela ionship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau MARTINA ROSS DAUGHTER 6503 WHITE ROCK ROAD SYKESVILLE, MU 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State South CARROLL CREM 112/2009 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licens 22. Name and Address of Facility Jw Zumswa FH & now Go. 6028 SYKESVILLE RO ELDERSBURG AD 21784 23a. Fart | Exter the disease or complications that caused the death. Do not enter the myte of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final 40 Can **Physician** disease or condition resulting in death) /Medical to (or as a consequence of): Examiner years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last quence of) Examiner The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 \(\sum \) Yes 2 \(\sum \) No Month Day 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tyes 24a. Was an autopsy performed?
1 Yes 2 You 4b. Were autopsy findings available prior to completion of cause of s certificate has birector, page 2 s death? 1 ☐ Yes 2 □ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 No Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Many of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending investigation nours after death.

neral Director: A

filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of on tifier 29c. License number 29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760, within 24 hours at To the Funeral Completely filled it To the I

> State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of chath (Item 23a) (Type, Print) Registrar's Signature

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2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** JÄNÜARY 2009 2:00рм **JERRY** HARLE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 8118 OLD PHILADELPHIA ROAD ROSEDALE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Year) Months Days Hours 1**%** M 2 □ F 216 28 9527 75 Director 02/15/1933 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ! r than "natural", or items 23a or 28a-f sho Its Medical Exandrements by notified at Director MD BALTIMORE ROSEDALE 1 ☐ Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8118 OLD PHILADELPHIA ROAD 21237 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 72 hours after 1 M2 Yes 2 □ No
If Yes, Give
Year or Dates: 52-55 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 □Yes 2X No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **VENDING** SELF EMP. VENDING is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Be CHARLES W. HARLE SR. IRMA **JACOB** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT HARLE 7532 BERKSHIRE ROAD BALTIMORE, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 I Burial 2 ☐ Cremation 3 ☐ Removal from State 1/14/09 GLEN BERNIE, MD 4 ☐ Donation 5 ☐ Other (Specify) GLEN HAVEN MEM. 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Fur 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Esophaa Cance /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed sician and burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a d be detached f o 9 Unknown 9 Unknown σ. To the Hospital or Attending Physician: The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 🗌 Yes 2 No 3 Probably 4 Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy performed? res 2 No this certificate 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturai 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of celtific 29c. License number 29d. Date signed (Month, Day, Year) 0 completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland 2001 South Greene Street

State Registrar Schwartz

Year)

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 8, Elizabeth Mary Hughes Januarv 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 9707 West Bexhill Drive Kensington Montgomery 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month Day, 1927) 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Massachusetts 028-28-1268 71 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 1√2 No Kensington Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20895 9707 West Bexhill Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Nursing Education Professor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Amelia Kulon Paustine Zawalick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) 9707 West Bexhill Drive, Kensington, MD 20895 Charles L. Hughes / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State Montgomery Crematorium Jan. 9, 2009 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Linensee Bethesda-Chevy Chase, Inc. M00896 7557 Wisconsin Ave., Bethesda, MD 20814-3501 23a. Part 1. Elter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate nterval Between Poset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Cancer of Unknown Primary Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐Yes 2 No 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

and burial-tran Box 68760, attending physician for use as the buris certificate be as nse ō ned by the at detached for o signed by t σ. equires that Records, been has this certificate of Vital Hospital or Attending Physician; filled in by the funeral After Division death. after death

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Examiner

Funeral

Director

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Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

/Medical

10a. State

Physician/Medical ☐Yes 2 No 9 Unknown 2 Completed Be 1 Tyes 2K No ဥ 27. Manner of Death Certification: 1 Natural 2 Accident 3 ☐ Suicide

29a. Certifier

25. Was case referred to medical examiner?

5 ☐ Pending investigation

6 ☐ Could not be determined 4 Homicide

28a. Date of Injury (Month, Day, Year) 28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

and manner stated. 29b. Signature and title of certifie

29c. License number D0051616

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

January 9, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick P. Smith, M.D., 5454 Wisconsin Ave., Suite #1300, Chevy Chase, MD 20815

State Registrar

Medical

24 hours

To the Hosp within 24 hou To the Funel completely fil

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. George Humphrey, III State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ January 5, 2009 Humphrey, III Medical Examiner George 0646 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number **Funeral** 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or ForeignMaryland Country Months Davs Hours Min Director 39 May 1. 1969 213-04-4462 1 XM 2 Usual Residence of Decedent 10a State I.O.c. City Town or Location 10b. County 10d. Inside City Limits Yes 2 X No 28a-f show Md. Baltimore Eastwood Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 7259 Gough Street 21224 U.S.A. 239 Funeral 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death . 1 XNever Married 2 Married Yes 2 X No White after Widowed Divorced If Yes. Give Yea Yes 2 X No specify: Specify: ۵ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 72 1 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 21215-0036 12thDisabled Disabled Com 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) George William Humphrey, Jr. Lillian E. Lorek Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Lillian E. Humphrey/Mother 7259 Gough Street Baltimore, Md. 21224 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, Date 2009 2008 crematory or other place) Burial 2 X Cremation 3 Removal from State Bayview Crematory Baltimore, Maryland Important Donation 5 Other Specify 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Kaczorowski Funeral Home, PA Avenue Baltimore, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician failure. List only one cause on each line Between Onset and /Medical Death Fentanyl and methadone intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed Physician/Medical 20b per fh 23a, pt.II,27,28a-f g888 2-2-09 vt X AMENDED X UNPENDED attending physician or use as the burial -Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 23e. Did tobacco use contribute to the cause of death? ⋧ σ. 1 Yes 2 No 3 Probably 4 Unknown Cocaine use Completed Records. s been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? certificate ✓ Yes 2 1 V Yes 2 Nο Hospital or Attending Physician: 25. Was case referred to medical director, 26.Place of Death (Check only one) Division of Vital Be examiner? Other; DOA Inpatient 2 V ER/Outpatient 3 this Nursing Home 5 Residence 6 ۵ 1 ✓ Yes No After the 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Natural Pending Yes 2x No 1-5-09 6:10 am unknown 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be Suicide determined (Specify) house 7259 Gough St. Baltimore, Md. Homicid 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 6, 2009 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. Assistant Medical Examiner

Registra DHMH 17 Rev 1/2001

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State

31. Date filed (Month, Day)

Market

32. Registrar's Signature

EMAKERA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7:30_A M Ohnson /Medical 4b. City, Town, or Location of Death institution, give street and number) 4c. County of Death Examiner Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Min. 1 ☐ M 2 🔀 F Days Hours Residence of Decedent Director 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Pes 2 □ No **Funeral Director** timore Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐Yes No Specify 3 Widowed 4 ☐ Divorced Completed by "natural" th and Mental Hygiene.
7 is marked other than "natur traumatic event, It of Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (7) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110111 Department of Heal Important: If Item 2 any injury or other once. Method of Disposition Pages 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses No 155 23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Annroximate Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed?
Yes 2 No Ren ailiere 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and litle of certifier D 2898 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21239 SPERLING 5601 MD LOCH RAVEN BALTO. BLUD

Registrar

State

31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

Records,

Vital

Division of

Registrar's Signature

Baltimore Maryland 21215-0036

P.O. Box 68760

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			1. Decedent's Name (First, Middle, Last)					Date of Death Month	h		3. Time of Death
	Physicia /Medic		Edna M. Jarvis					January	Day 20	Year 009	3:00 A M
and Control	Examin		4a. Facility Name (If not institution, give street an	d number)	_	4b. City, Town, or	Location of Death		4c. County		
			125 Cherry Hill Road			Street			Hari		County
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	 Date of Birth (Month, Day, 	Year)	Birthp Coun	lace (State or Foreign htry)
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	land ow	}	10a. State 10b. County	10c. City	y, Town or Lo	cation				1	0d. Inside City Limits
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	r 28a	irec	10e. Street and Number	4		10f. Zip Code		10	Og. Citizen of V	Vhat Coun	itry?
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	death	ner	11. Marital Status 12. Was	Decedent Ever in U. ed Forces?	S. 13. \	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No-		e - Americ	
9	72 hours after death with the Maryland natural", or Items 23a or 28a-f show Iteal Evain in frout be matthed at		1 Never Married 2 Married 1 1	/es 2. Mar S, Give		I∐Yes 2XX No	Specify:	rican, etc.)		k, White, e	
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ary	shou and N s mar umat		19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ig Address (Street a.	nd Number or Run	al Route Number,	City or Town,	State, Zip	Code)
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ore	es 1 a of He fitem		20a. Method of Disposition	20b. P	Place of Disponentery, cren	sition (Name of natory or other place)	Date 2	20c. Location -	City or To	wn, State
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Most and Experiment to a natural be nother any once.		21. Signature of Funeral Service Deepsee	4	_ 22	. Name and Address Burgee-He	of Facility nss–Seit:	z Funera	1 Home.	Tnc	
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Division of Vital Records,	Atten deat ctor: y the	fica	3 Suicide 6 Could not be 28e,	Place of Injury - At ho	ome, farm, stre			28f. Location (Str	eet and Numb	er or Rura	l Route Number.
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	To the Hospital or Attending Physician: The I within 24 Hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: 7 Check only one) 1 Medical Examiner: On and	o the best of my kno the basis of examina manner stated,	wledge, death	n occurred at the tim vestigation, in my op	e, date and place, inion, death occur	and due to the cared at the time, da	ause(s) and ma	anner as s and due to	tated. the cause(s)
	To the vithin To the comple	Me	29b. Signature and title of certifier	aor orarou,		29c. License	number	29	d. Date signed	d (Month, i	Day, Year)
	. > - 0		Matel Som	navn, 1	M.D.	0	520	(6	1/0	7/	2009
			30. Name and address of person vino completed	cause of death (Item	1 23a) (Type, I	Print)	1 0	2 1		0	Hmore M
	le			CA 01 1	o far	+ JJ/	rd 3	1 rest	# 610,	Bal	TIMORE, M
	Sta	_	31. Date filed (Month, Day, Year).	32. Pegistrar's Signa	ture	- A					
	Registr	ar	JAN I 3 2009	Drewn ,	19. Jac	erka					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Patricia Ruth Jenkins January 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON MUKL 24 Hrs. 8. Date of Birth Min. (Month, Day, Year) July 18, 19 5. Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Months Days Hours 213-30-0561 77 Ĩ931 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits N/A 1X Yes 2 □ No MD Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6109 Falls Road 21209 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🕅 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Donald Fair, Elementary/Secondary (0-12) College (1-4or 5+) Attorney at Law Legal Secretary 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Kreiner Ruth Florence Parsons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clifton Jenkins (husband) 6109 Falls Road, Baltimore, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park 1/12/2009 Baltimore, Maryland 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) sequentially list exhautions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co Due to for as a conseq IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 23d. Date of delivery 3 🗆 Ectopic pregnancy Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 2 No 1 ☐ Yes 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

Examiner attending physician and for use as the burial-tran P.O. Box 68760 certificate be the detached signed by Division of Vital Records, peen (has this certificate Hospital or Attending Physician;

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

Physician

/Medical

Examiner

Director

Funeral

Completed

Be

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Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is narred other than "natural; or items 23a or 28a-f show important: If them 27 is narred other than "natural; or items 20a or 28a-f show any injury or other traumatice even, this Modical Exa, free mist be notified at

Physician /Medical

Baltimore, Maryland

Physician/Medical 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical examiner? Be 1 ☐ Yes P 27. Manuer of Death Certification: 1 Natural 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

29b. Signature and title of certifier

MPH mD

and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOUTE 6

CHARLES ST BALTIMORE 21204

State Registrar 31. Date filed (Month, Day,



Amend #25 per ME G877 1/14/09 TT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 26 per me g887 1-13-09 yr

State of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** /Medical Town, or Location of Death **Examiner** Wer 1001 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, **Funeral** Months Days Min. Hours Many Director 10a. State 10b. 10c. City Town or Location 10d. Inside City Limits County or 28a-f show Examiner must be notified at Yes 2 No Directo +(m)10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? or items 23a Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Completed by 3 Widowed 4 Divorced "natural" permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DQ NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P 19a Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) 1Dn Name and Address of Facility 21. Signate of Funeral Service Licensee neral 10 BaltoMD 23a. Part1. shock the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the disease, or complications that caus or heart fail re. List only one cause on each Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due, **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in int I 23e. Did tobacco use contribute to the cause of death? 2 4 Unknown 1 🔲 Yes 2 🗌 No 3 ☐ Probably Be Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes No 1□ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t UNK 1 Natural 5 Pending investigation MK To the Hospital or Attendi within 24 hours after death, To the Funeral Director: A completely filled in by the fu 1 🗌 Yes down 2 Accident 3□ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City of Town, State) 4 ☐ Homicíde (to me certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) address of person who con ted cause of death (Item 23a 31. Date filed (Month, Day, Year)

JAN 1 3 2009 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar					te of l				Reg. No		00490
	Physici	an	Decedent's Name (First, Middle, Las	t)							Date of De Month	ath Da	ıy Year	3. Time of Death
	/Medic	_		Jordan							January			11:15 A.M
*.	Examin	er	4a. Facility Name (If not institution, give	street and number)			, Town, or		of Death		40	. County of Death	
			Fairhaven 5. Social Security Number 6. Se	7.4	an In use	ast birthday)		rkesv	ille if Under	24 Hrs	P. Data of Bis	46	Carrol	
1	Funeral Director		216-16-6317	Å M 2□F	84		Months		Hours	Min	8. Date of Bir (Month, Da Nov • 25	9,19	24	nplace (State or Foreign untry) MD
	and	1	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	f sho	ò	MD Carroll			kesvi								1 ☐ Yes 2X No
	28a-	Director	10e. Street and Number			/ RESVI.	-1	ip Code				10a Ci	tizen of What Cor	untry?
7	A o o	٥	7200 Third Avenue					21784				U.S		, .
	Jeath The 2:	era	11. Marital Status	12. Was Deceden	t Ever in U.	S. 13. V				igin? (Spec	cify Yes or No Rican, etc.)		14. Race - Amer	ncan Indian,
21215-0036	s 1 and 2 should be filed within 72 hours effer death with the Maryland. It health and Mental Aggiene. It health and Mental Aggiene. It marked other than "naturel", or Items 23a or 28a-f show other treumstic event, the Medical Examinar must be notified at	by Funerai	1 ☐ Never Married 2(X) Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 XYes 2 If Yes, Give Year or Dates] No			ecify Cuba 2 XNo	n, Mexica Specify		Rican, etc.)		Black, White Specify: Whi	
ŏ.	2 hou	ted	15. Decedent's Ed	ucation		16a. Deced	dent's Us	ual Occupa	ation			16b. K	(ind of Business/l	ndustry
_	within 7 ene. than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or	5+)	(Give life, L	kind of w	ork done d use retired	during mos ')	st of workin	ng			
	filed within Hygiene. Sther than ant, Item	NO.	10		,	Mach	inist	t				Pro	ctor & G	Gambill
	at Hy 1 oth	Be	17. Father's Name (First, Middle, Last)						18. Moth	er's Name	(First, Middle	, Maidei	n Sumame)	
yla	should be ind Mental I marked o	2	Johann Jordan						Eliz	zabetl	h Moss			
-	2 shc and and and and		19a. Informant's Name/Relationship (7				-						or Town, State, Z	ip Code)
	1 and 2 si Health an tem 27 is pother treus		Mr John Jordan /S	on	Jook B				Road		ville N			
Baltimore,	Pages 1 nent of H int: If ite iry or of		20a. Method of Disposition 1 💆 Burial 2 □ Cremation 3 □	Removal from State	9 0	lace of Dispo emetery, cren	natory or	other plac		Jan.			ocation - City or 1	
ij.	t. Pa tmen tant: ijury	,	4 Donation 5 Other (Specify		Ced	lar Hil			-	200			oklyn, M	
Bal	permit. Pages 1 an Department of Heal Important: if item 2 eny injury or other <u>ones</u> .		21. Sometimes of Funeral Service Licen	Nick	MOIL									remation MD 21061
F	Physician /Medical	The state of the s	23a. Part1. Enter the disease, or composition, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	a	nenti	· E1	er the mo	ode of dyin	g, such as	cardiac or	r respiratory a	rrest,		Approximate Interval Between Onset and Death
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	law requires that the death certific as been signed by the attending p 2 should be deteched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death 3	Ectopic Other (s	pregnancy specify)					23d. Date of deliment	very Day Year
ds, P	ires that signed b d be dete	ρ	Part II. Other significant conditions of	ontributing to death	but not resi	Iting in the ur	nderlying	cause give	en in Part	l.		obacco Yes 2		the cause of death?
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E .	The ate h page	Completed									24a. Was auto perfo	psy ormed?_	death?	topsy findings available completion of cause of 2 No
/ita	cian	Be	25. Was case referred to medical examiner?	Liie-i						e of Death	(Check only o	one)		
of Vital	Physic this c	ဥ	1 Yes 2 No	Hospital: 1 Inpat		ER/Outpatien			4 (N				6 ☐Other (Spec	cify)
Z	ling f	lon	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of In (Month, D	ay Year)	28b. Time of Injury		28c. Injun Work			8d. Describe	how inju	ry occurred	
	or Attending Physician: fter death. Director: Atter this certifics in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		njury - At ho	me, farm, str	M eet, facto		Yes 2		8f. Location (City or To	Street a	nd Number or Ru e)	ral Route Number,
ם	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	Check only 2 Medical Exam	ysician: To the bes	of examina	wledge, death	n occurre	d at the tim	ne, date ar	nd place, a	and due to the	cause(s	i) and manner as	stated.
·	the hin 2, the 1	Jed	1	and manner s	stated.									
	To with	4	29b. Signature and title-el/centifier	110	MS)	29	9c. License	5 8	127		29d. Da	ate signed (Month	l, Day, Year)
^	<i>Y</i>]		30. Name and address of person who	completed cause of		23a) (Type,		307		10ch	mingle	/ /	110 7	1157
10	1 1	1 1								14 6-1			/ 1 1 / 2	

Registrar

Physicia /Medic Examin

Funeral Director

	For State Registrar		State o	of Marylai		epartment Certificate				giene Reg. No	/	09	00491
	Decedent's Name (First, N	fiddle, Las	st)						2. Date of Dea	ath			3. Time of Death
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ai er	4a. Facility Name (If not instit	tution, give	street and nu	ımber)		4b. City, To	wn, or Location	of Death		40	. County	of Death	
	Frederic	k Mem	orial l	Hospita	1		Frede	rick				Fred	erick
	5. Social Security Number	6. Se		7. Age (In yrs	. last birtho	fay) If Under 1 Months I	Year If Unde	r 24 Hrs. Min.	8. Date of Birt (Month, Da	h v Year		9. Birth	place (State or Foreign intry)
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ă	10e. Street and Number		_			10f. Zip C				10g. Ci	tizen of	What Cou	ntry?
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n n	11. Marital Status		Armed Fo		J.S.	 Was Deceder If Yes, specify 	nt of Hispanic O / Cuban, Mexica	origin? (Spi an, Puerto	ecity Yes or No- Rican, etc.)			ce - Ameri ck, White,	ican Indian, etc.
Σ	1 ☐ Never Married 2 ☐ 3 ☑ Widowed 4 ☐ Divo		1 TYYes If Yes, G	ive Dates: 1941	_/.5	1 □ Yes 2√	No Specify	y:			Specif	y: 1.7h	nite
ba	**	edent's Ed		Dates. 1941		ecedent's Usual	Occupation			16b. k	(ind of B	usiness/Ir	
olet	(Specify only h	ighest grad	de completed)		(0	Give kind of work fe. DO NOT use	done during mo	st of worki	ing				,
mo	Elementary/Secondary (0-12	12)	College (1-40r 5+)	r	nachinis	t			te	xti	le in	dustry
Be C	17. Father's Name (First, Mic	idle, Last)						her's Name	(First, Middle,				icino (.i. y
To B	Lewis Fran	k Jam	nes				Sa	die G	Gerlock				
_	19a. Informant's Name/Relat	tionship (7	Type. Print)		19b. N	lailing Address (5	Street and Numi	ber or Rur	al Route Numbe	er, City	or Town	, State, Zi	p Code)
	Lynn Rinehar	t / n	niece		73	323 Gran	alta Ci	rcle,	Freder	cick	, M	217	'02
	20a. Method of Disposition			20b.		isposition (Name crematory or othe			Date				own, State
	1 ☐ Burial 2 【XCremat 4 ☐ Donation 5 ☐ Othe			State I		ourg Cre		1/6/2	2009	Smi	thsl	ourg,	MD
	21. Signature of Funeral Ser												ral Home
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	23a. Part 1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	e, or comp List only o	a.	caused the dea each line.	nia		of dying, such a	as cardiac	or respiratory a	rest,			Approximate Interval Between Onset and Death
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Examiner	Cause (Disease or injury that initiated events	1	C										
ŭ	resulting in death) Last		Due to	(or as a conse	quence of)								
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<u>></u>	Part II. Other significant cor	nditions co	ontributing to o	I			se given in Part	il.	23e. Did to	bacco	use con	tribute to t	the cause of death?
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<u>s</u>	Acute R	enal	failur	e					24a. Was	an	24b.	Were auto	opsy findings available
E									autop perfor 1 □ Yes	rmed? 2 ₩₩		death?	ompletion of cause of
ě	25. Was case referred to me	dical					26. Plac	ce of Death	n (Check only o				
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Ë	27. Manner of Death	ndina	28a. Date	of Injury oth, Day, Year)	28b. Tin	ne of 280	. Injury at Work?		28d. Describe h	now inju	ry occur	red	
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ţį		ould not be termined	28e. Place build	e of Injury - At h	nome, farm	, street, factory, o	office		28f. Location (S City or Tox	Street a	nd Numl e)	ber or Rur	al Route Number,
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Medical Certification: To			niner: On the			death occurred at or investigation, in							
ž	29b. Signature and title of ge	rtifier				29c. l	_icense number			29d. Da	ate signe	d (Month,	Day, Year)
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			~ I>			1							
	30. Name and address of pe		completed cau	se of death (Ite	m 23a) (Ty	pe, Print)							
	30. Name and address of pe	rson who		se of death (Ite	m 23a) (Ty	pe, Print) Fred	erick m	an	21701				
е		rson who		se of death (Ite	em 23a) (Ty	pe, Print) -, Fred	erick m	UD.	21701				

DHMH 17 Rev 1/2001

Sta Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieneo

			For State Registrar	State	e of Ma	ryiano	_	artment of r <i>rtificate of</i>			-	Reg. No	7 0 0 9	00492
F	Physicia	an	1. Decedent's Name (First, Middle,		TED	SCHE	ידר				2. Date of De	eath	ay 20 Year	3. Time of Death
	/Medic Examin	al	EDWARD JOS3 4a. Facility Name (If not institution,			SCRE	עדט	4b. City, Town, o	r Location	n of Death	U	40	County of Dear	h
			Franklin Squar	e HOSp	ital	CONT	er	ROSC If Under 1 Year	dak	er 24 Hrs.	9 Date of Bir	t	Battimo	re
	uneral irector		212-42-1951	6. Sex \ 11 <u>√</u> M 2□		65	st birthday) Yrs.	Months Days	Hours		8. Date of Bir (Month, Da 01/05	ay, Year /19	44 MA	hplace <i>(State or Foreign</i> nuntry) RYLAND
land	MO III		Usual Residence of Decedent 10a. State 10b. County			10c. City,	Town or Lo	ocation	100					10d. Inside City Limits
e Mary	a-f sh	Director	MD BALT	IMORE		RC	SEDA	LE					<u> </u>	1 □Yes 2 No
vith the	a or 28 beng	Dire	10e. Street and Number	DD 3177				10f. Zip Code	7			10g. C	itizen of What Co	untry?
leath v	ns 23a	Funeral	8041 EDGEWAT 11. Marital Status	12. Was [Decedent E	ver in U.S	. 13.	Was Decedent of H If Yes, specify Cub		Origi <u>n</u> ? (Spe	ecify Yes or No	o-	USA 14. Race - Ame	
2 should be filed within 72 hours after death with the Maryland and Merital Hybiene.	production of the product of the pro	þ	1 ☐ Never Married 3☐ Widowed 4 ☐ Divorced	ed 1 🔲 Y	d Forces? 'es 2 12 No , Give or Dates:	0		If Yes, specify Cub 1 ☐ Yes 2 No			Rican, etc.)		Black, White Specify: W	
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and 2 sh	27 Is n r traun		19a. Informant's Name/Relationshi MARY E. JERSC		/ / WIF	'T'	8041	ing Address (Street				-	E MD	
ד – ע	item		20a. Method of Disposition	,				osition (Name of matory or other pla	ce)	AVE	ate	20c. l	Location - City or	Town, State
Pag	lury o		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		rom State	MET	RO C	REMATOR	Y	1/13			LTIMOR	
permit. Page	Important: If it any injury or conce.		21. Signature of Furneral Service L	icersee			2	2. Name and Address 1211 CH	ESAC	^{cility} CVA CO AV	CH/RO E BAL	SED TIM	ALE FUI	NERAL HOME D 21237
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COLDS, w requires th	for the Funds are little for all the this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	þ	Part II. Other significant condition	18 CONTIDUTING	to death bu	t not resu			ven in Fai	· · · · · · · · · · · · · · · · · · ·				robably 4 Unknown
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hysici	his cer I direct	10 B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	1 🗹 Inpatie	nt 2 □ E	ER/Outpatie	ent 3 DOA Ott	hor:				6 ☐ Other (Spe	ecify)
	After t funera	ion:	27. Mar ver of Death 1 ☑ Natural 5 ☐ Pending		Date of Injur (Month, Day	y Year)	28b. Time o Injury	Wo	ıry at rk?]Yes 2[!	28d. Describe	how inj	ury occurred	
Attend	ector: by the	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	ot be 28e. P	Place of Inju	ry - At hor	me, farm, si	treet, factory, office	1165 21		28f. Location City or To	(Street a	and Number or R	ural Route Number,
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,	Λ		1 Alm 100	M	0	-4- 44		RES		00		01	12/200	
(4		30. Name and address of person v	d Faw(cause of de	ath (Item	23a) (Type) Franklin	501	vare 1	Dr. Bal	tim	ore, MD21	237
	Sta Registr		31. Date filed (Month, Day, Year)	2000	32. Registra	r's Signat	ure	,	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 00493 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month / Day **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMER 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Months Hours 1 □ M 2 🖾 F Days Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiens in Internative rivers are useful with the Matyla Department of Health and Mental Hygiens in Important; if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Madical Extendite must be rediffed at once. Director 1XYes 2 □ No MONTGO HEATON Pages 1 and 2 should be filed within 72 hours after death with the Inent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23a or 28a. 10e. Street and Number 10g. Citizen of What Country? USA 2090Z Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 ☐ Yes 2 If Yes, Give 1 Never Married 2 Married 2**⋈** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: ASIAN ģ 3 ₩Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHANG W00 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 KIN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-13-09 21. Signature of Fulleral Service Lice 10220 GUILFORDRD, UK 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ARDIOMYOR MANY YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner YTRIAL FIBRILLATIO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) e Hospital or Attending Physician: The law requires that the death certificate be executed to the cours after death.

24 hours after death.

Pureral Director: After this certificate has been signed by the attending physician and eleily filled in by the furneral director, page 2 should be detached for use as the burliar-transit VSPHAGIA Due to (or as a consequence of) HRITIS COSTE Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month 4 Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 □ Yes 2 🗷 No 24b. Were autopsy findings available prior to completion of cause of death? 2 □No Division of Vital 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10021033 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13000 GEORGIA AVE SILYER SPRING, MD 20906 M. D

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

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			1 - State Registrar 1. Decedent's Name (First, Middle,	Logt	Ce	rtificate of	Death	To D (5	Reg. No. Z	109	0049
	Physici		T. Decedent's Name (First, Migdie,	,	Knight			2. Date of De Month Januar	Day	Year 009	3. Time of Death
pro.	/Medic Examir		4a. Facility Name (If not institution,			4b. City, Town, o	r Location of Death			ity of Death	0433 A
1			3 Queen Eleanor			Elkto			Ced		
В	Funeral Director		5. Social Security Number 219-34-5802	. Sex 7. Ag	e (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	rth ay, Year) 0. 1938	Count	
			Usual Residence of Decedent					July 30	J, 1930		yland
	show	5	10a. State 10b. County		10c. City, Town or Lo	ecation				10	od. Inside City Limits 1 ☐ Yes 2 🕱 No
	the M	rect	Maryland Cecil 10e. Street and Number		E1kton	10f. Zip Code			10g. Citizen o	f What Count	
	h with	Funeral Director	3 Queen Eleanor	Drive		2192	1		-	ted Sta	
	after deatl	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H		pecify Yes or No	o- 14. Ra	ace - America ack, White, et	an Indian,
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Maryland	d 2 sh th and 17 is n traun		19a. Informant's Name/Relationship Mary Jane Knigh			ng Address (Street					Code)
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E C	Pages nent of I		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		20b. Place of Dispo cemetery, cred Immaculat	natory or other place C	⁹⁾ Janua rv 2009	ry 8,		rry Hil	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natur any Injury or other traumatic event, The Medical once.		21. Sign ture of Funeral Service Lie	censee	Conception	Name and Address Cks Home	ss of Facility for Fund	erals,	P.A.		89.00 NO.00
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	Hos Fur tely	Medical (29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the best aminer: On the basis o and manner sta	t examination and/or in	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and n date and place	nanner as sta , and due to t	ated. the cause(s)
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			pose //	N		DY	4716		James	TY 6	, 2009
			30. Name and address of person wh	o completed cause of d	eath (Item 23a) (Type,	Print)	1 1	4 (\ _		1
			21 Data file (Manth Day Year)	11 Cu .	High S	TH	Kton	1001	12	19.	21

DHMH 17 Rev 1/2001

Registrar

ORIGINAL.

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State of Maryland / Department of Health and Mental Hygieney 00495 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Sanford Kersten \mathbf{A}^{M} 2009 1:45 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July | 1 Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**√** M 2□ F Months Days 91 233-01-5668 Ohio Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show Director 1 □Yes 🏋 No MD Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Pomona West, Apt 6 21208 **USA** Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1★17es 2 □ No If Yes, Give Year or Dates: ₩₩ II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: White ğ 3 ☐ Widowed 4 ☐ Divorced W II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Industrial Engineer Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Kersten Molly Sebulsky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health a Important; if item 27 is any injury or other trau once. Carol Novick Kersten/ wife 2 Pomona West, Apt 6 Pikesville, MD 21208 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 1/9/09 Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring 22 Name and Address of Facility

Cremation Society of Maryland, Inc.
299 Frederick Rd Baltimore, MD 21228 C. Colle Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SNOKE **Physician** Neek /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying (ause (in the cause) that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): burial-Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No page or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) NDS PLU 1 Yes 2 WNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending s after death. investigation 1 ☐ Yes 2 ☐ No the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide Hospital To the Hospital within 24 hours a To the Funeral I 29a. Certifier 🖅 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. CUML ST TOWSON NO 21204 AMON CHARUES S 31. Date filed (Month, Day, Year). 32. Registrar's Signature

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State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Elegia Krupinsky Tanuary 8:20 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Keswick Multicare Center Baltimore N/A Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Jurie 25, 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Days Hours 1 □ M 2 🔭 F 215-24-4212 94 Director Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Director XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 W 40th Street 21211 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White Completed by 3 Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk New System Bakery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Biaggio Ross Felicia Malistpina ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John T. Krupinsky (son) 21 Tintern Court, Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place)
Moreland Memorial 20a. Method of Disposition Date 20c. Location - City or Town, State 1XD8urial 2 ☐Cremation 3 ☐Removal from State 1/10/2009 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician emention /Medical Due to (or as a consequence of): Examiner Years Cerebral was enlar a condent Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 MNO Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

TOESREGOR, 31. Date filed (Month, Day, Year)_

OT BOBELLE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

760 W. 404 STREET, BALTIMORE,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death KENOALL FLORIA 1 Anuare 10 GOS 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death HARBOR HOS PITAL Baltimore 8. Date of Birth (Month, Day, Nov. 28 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 K F Months Days Hours 65 216-42-2478 1943 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ▼ No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7725 Locust Grove Road 21060 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🔀 Married 1 □Yes Ž\□No Specify: White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telemarketer Telemarketing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Adam Grynowicki Viola Piker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. James Kendall /Husband 7725 Locust Grove Road Glen Burnie MD 21060 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licenses Serivces 1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER BREAST WITH METASTASIS Due to (or as a consequence of): X 10 da PNEUMO NIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown 9 Unknown Part II. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? THROMBUCY TORENIA 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy 2 0 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ N 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 D Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 □Yes 2 □ No

Examiner The law requires that the death certificate be executed and burial-tran Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be eximiting 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show

Director

Funeral

2

Completed

Be

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MD

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

purmit. Pages 1 and 2 should be filed within 72 hor Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura may injury or other traumatic event, Im. Medical Egone.

Physician

/Medical

Examiner

Saltimore, Maryland 21215-0036

Medical

State Registrar

Physician/Medical <u></u> Completed Be ဥ Certification:

2 Accident 3 ☐ Suicide 4 Thomicide 29a. Certifier

6 ☐ Could not be determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

MD

29c. License number RES DOD

HANDUER ST.

29d. Date signed (Month, Day, Year)

21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BNIGELITA SouTH 58TADILLA 300/

31. Date filed (Month, Day, Year)

\$2. Registrar's Signature

and manner stated.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

Physician /Medical Examiner

Director

Funeral Director show

r than "natural", or items 23a or 28a-f shov

Funeral 72 hours after Baltimore, Maryland 21215-0036 ð Completed I Hygiene. permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important: If Item 27 is marked other 1 any Injury or other traumatic event, In Be **Physician** /Medical Examiner ner be executed Exami slcian and burial-trans physician s the burial Physician/Medical attending ph for use as the P.0. Division of Vital Records, Completed by sign be page 2 s director, Be Medical Certification: To this funeral After Hospital or Attending death. 24 hours after death Funeral Director: filled in by the completely within 2. btl

1. Decedent's Name (First, Middle, Last) John Francis Kloch, Sr. 2009 January 3:42 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Baltimore Co. Towson Gilchrist Nursing Home 9. Birthplace (State or Foreign Country) New York If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 6, 1924 5. Social Security Number 7. Age (In vrs. last birthday) Months Days Hours Min 1 M 2 F 84 216-18-9531 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Edgemere 1 Tyes 24 No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21219 United States 6516 North Point Road 12. Was Decedent Ever in U.S. Armed Forces? ATMYES 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Tes 2 No Specify. Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Erector Steel Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cleo Amanda Rigby Adam Gerome Kloch 19a. Informant's Name/Relationship (Type. Print)
Mrs. Sharon Kikola (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1925 Ewald Ave. Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/12/2009 Baltimore,MD 4 ☐ Donation 5 ☐ Other (Specify) Baltimore National 21. Signature of uneral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the shock, or hear a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STROKE WELKS disease or condition resulting in death) Due to (or as a consequence of): ATRIAL FIBRILIATION MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OF THE TUNSIL CANCER 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No SEPSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSFICE 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DANIEUE

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32

egistrar's Signatu

DOBERAGAN, MD

D64395

6565 N CHARLES ST, SUITE 209

JANUARY 8, 2009

BALTIMORE, MO 21204

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

*60	Physici /Medic		Eileen	B. Kelman	rtin				Month January	Day	Year 109	4:02 A M
4.	Examir		4a. Facility Name (If not institution, g			4b. City, Town, o		on of Death		4c. County of		
w.d			Stella Mar 5. Social Security Number 6.		(In yrs. last bir	Timoniu		ler 24 Hrs. 8	. Date of Birth	Balti		
	Funeral Director		217-24-4890 Usual Residence of Decedent	1 M 2 F 80		Yrs. Months Days		s Min.	Dec. 29	, 1928	Mar	place (State or Foreig oryland
	/land		10a. State 10b. County	1	10c. City, Town	n or Location					1	10d. Inside City Limits
	a-f sh	ctor	Maryland Baltim	ore	Ti	monium						1 □Yes 🎗 □ No
	or 28	Dire	10e. Street and Number			10f. Zip Code			1:	0g. Citizen of W	hat Cour	ntry?
	s 23a	era		Valley Road				Orining (Const	f . Wa a av Na	USA	A1	can Indian,
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or items 23a or 28a-f show amportant: if Item 27 Is marked other than "Adical Evanting routh by notlined at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ሺ Divorced	12. Was Decedent Ev Armed Forces? 1 _Yes 2 _XNo If Yes, Give Year or Dates:		13. Was Decedent of lif Yes, specify Cub 1 ☐ Yes 2 ☑ No			can, etc.)		, White,	
5-0	72 hou	eted	15. Decedent's (Specify only highest of	Education	16a	Decedent's Usual Occu (Give kind of work done	pation	ast of working		16b. Kind of Bus		•
altimore, Maryland 21215-0036	should be filed within and Mental Hygiene. Is marked other than "Is aumatic event, In Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Adn	(Give kind of work done life. DO NOT use retire Iinistrative	Ass	t.		John Ho Univers	ity	15
pul	be file d oth event	Be	17. Father's Name (First, Middle, La.							1aiden Surname)	
ryla	d Mer narke natic	ဥ	Thomas I.	Bolton	101	M 12 A A A A A A A A A A A A A A A A A A	1	lellie		mings	24-4- 70	- 0-1-1
Mai	d 2 sho Ith and 27 Is ma		19a. Informant's Name/Relationship Janet Krupsaw /	Daughter	190	. Mailing Address (Street 2005 Galwa		Road		: Hill,M		
re,	s 1 and 2 if Health Item 27		20a. Method of Disposition		20b. Place o	Disposition (Name of ry, crematory or other pla		Dat		20c. Location - 0		
m 0	Pages nent of I		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			ind Mem. Par		1/13/	2009 B	altimor	e, M	Maryland
Balti	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service of	ensee		22. Name and Addre		•	Home,In			rk Road 4d.21204
			23a. Part 1. Enter tile disease, in conshock, or heart failure.	no cation that caused the one cause on each line	ne death. Do	not enter the mode of dy	ing, such	as cardiac or i	espiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_a LUNG CANO	ER							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):						
		e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence	of):					-	
W	cuted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C								
0,	oe exe sian ar urial-ti	Exa	resulting in death) Last	Due to (or as a	consequence	of):						
68760,	cate b	dica	•	d								
O. Box 6	ne death certificate be executed the attending physician and hed for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t g ☐ Unknown	Fetal death	3 ☐ Ectopic pregnants ☐ Other (specify)				23d. Date Mor		rery Day Year
σ.	The law requires that the de ate has been signed by the a bage 2 should be detached to		Part II. Other significant conditions	contributing to death but	not resulting in	n the underlying cause gi	ven in Pa	rt I.	23e. Did tob	acco use contri	bute to t	he cause of death?
rds	w requires been sign should be	ed by							1 X Ye	s 2 No	3 ☐ Prot	bably 4 🗌 Unknowi
of Vital Records,	e law re has be	Completed							24a. Was ar autops	24b. W	ere auto	opsy findings available
E H	: The cate h	Son							perforn 1 □ Yes 2	ned? de X No 1	eath? □Yes	ompletion of cause of 2 □ No
Vita	Physician: The r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Otl	hor	ace of Death (HOCDICE
	ding Physician: The h. After this certificate h funeral director, page	Certification: To	1 ☐ Yes 2 🙀 No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Day,		Time of 28c. Inju	4 🗆			nce 6 X Othe w injury occurre		HOSPICE
ion	Attending For death. ector: After by the funera	atio	1 Natural 5 Pending 2 Accident investigat	on	rear) I		rk?]Yes 2	□No				
Division	I or Attend after death Director: /	tific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		y - At home, fa (Specify)	rm, street, factory, office		28	f. Location (St. City or Town		r or Rura	al Route Number,
	oital o urs af eral Di		29a. Certifier 1 ☐ Certifying	Dharaistan Ta tha bank of		death account of the last						
	To the Hospital or Attent within 24 hours after death to the Funeral Director: completely filled in by the	Medical		Physician: To the best of aminer: On the basis of e	examination ar	id/or investigation, in my	opinion, o	e and place, an death occurred	at the time, da	ause(s) and ma ate and place, a	nd due to	o the cause(s)
	Within To the comp	Me	29b. Signature and title of certifie	<i>(</i> 2		29c. Licen	se numbe	er	25	9d. Date signed	(Month,	Day, Year)
			1910	ISLAND		R19	1979	12		1/12/09		
	5		30. Name and addless of person wh									
_		oto.	JACKIE JONES, C			VALLEY RD.	TIM	ONIUM,	MD 210	193		
	Sta Regist		JAN 1 2 21	1	1	1						
DH	MH 17 Rev 1/2	2001	W1112 2 .33 / 1	15.201	P. 1	garke						
						ORIGINAL.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		laryland / [-	ent of F cate of I		Mental H	ygien Reg. N		09	00500
	Physicia /Medic		1. Decedent's Name (First, Middle John Martin Ke	,					2. Date of E Month Janua	D	ay 200	Year)9	3. Time of Death 12:36 AM
F D	Examin uneral irector		4a. Facility Name (If not institution Carroll Hospit 5. Social Security Number 217–28–2278 Usual Residence of Decedent	al Center	ge (In yrs. last birt	V	Jestmin nder 1 Year	nster If Under 24 Hi Hours Min	ath S. 8. Date of E	3irth Day, Yea	ar)	roll 9. Birthp	lace (State or Foreign try) sylvania
Maryland	f show	ō	10a. State 10b. County MD Carro	011	10c. City, Town	or Location pstead						11	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
h with the l	23a or 28a- et by notif	Funeral Director	10e. Street and Number 3860 Normandy	Drive			. Zip Code	.074		10g. C	Citizen of W	Vhat Coun	try?
2.1.3-100.30 Jin 72 hours after death with the Maryland	Department of result and western regions in the 23a or 28a-f show mortanti if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I we Madical Even in a route by notified at once.	Completed by Funer	11. Marital Status 1 □ Never Married 2 ☑ Mar 3 □ Widowed 4 □ Divorced 15. Deceden (Specify only highe Elementary/Secondary (0-12)	If ₹ès Give	7 No 51-53 16a.	1 □Ye Decedent's (Give kind of	es 2∏ No Usual Occup	Specify: ation during most of w	(Specify Yes or Nerto Rican, etc.)			WII	ite
filed with	ther the	Com	1 2 17. Father's Name (First, Middle,	5		te	acher	18. Mother's N	ame (First, Midd	ile, Maide		catio	on
ylan buld be	arked o	To Be	Elmer Martin					Aleda	Clair N	Mead			
Mar nd 2 sho	27 is m r traum		19a. Informant's Name/Relations June Keck/spo		19b.	U	•		Rural Route Nun e Hampst		,	State, Zip	
altimore,	ant; If Item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (S	3 ☐ Removal from State	20b. Place of cemeter	Disposition ry, crematory	(Name of or other plac	e)	Date	20c.	Location -	City or To	wn, State
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/N	physician and ledical aminer is the burial-tran it	edical Examiner	23a. Part1. Enter the disea e, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last	a. Due to (or a Due to (or a c.	de the death. Do riffine. (ADSC L 2) s a consequence of the consequen	not enter the EKD T/Of): ET (mode of dyin	g, such as card	iac or respiratory	arrest,			Approximate Interval Between Onset and Death ISARS
the death certific	when the notes are ceau. To the Fundral Director. After this certificate has been signed by the attending plot on pletely filled in by the funeral director, page 2 should be detached for use as to completely filled in by the funeral director.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death at time of death		pic pregnanc er (specify)	у		-	23d. Dat Mo	te of delive	ery Day Year
rdS, P	an signed b uld be deta	by	Part II. Other significant conditi	_	but not resulting in	the underly	ing cause give	en in Part I.			,		ne cause of death? pably 4 🗆 Unknown
VITAL RECORDS, iclan: The law requires t	ficate has bei r, page 2 sho	Completed							pe 1 □ Yes	topsy rformed? 2 X	? 5	orior to co death?	psy findings available mpletion of cause of 2 No
OT VIII Physicia	this certi Il directo	To Be	25. Was case referred to medica examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpa	tient 2 ER/Ou			er: 4 🗆 Nursing	Home 5 Re		6 □Oth	er (Specif	y)
VISION C	or; After the funera	ertification:	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	gation not be	lay, Year) I	Time of njury M		yat <br Yes 2 □ No	28d. Describ				
UIVI tal or At	al Direct ed in by	Certifi	4 Homicide detern	nined 28e. Place of It	njury - At home, fa etc. <i>(Specify)</i>	rm, street, fa	ctory, office			Street (Sown, Sta		er or Rura	il Route Number,
e Hospi	ne Funer	edical	29a. Certifier (Check only one) Check only one) Certifying Certi	ng Physician: To the bes Examiner: On the basis and manners	of examination an	e, death occu nd/or investig	irred at the til ation, in my c	me, date and pla pinion, death oc	ace, and due to to courred at the time	ne cause ie, date a	e(s) and ma and place, a	anner as s and due to	stated. the cause(s)
70 th	To th	Σ	29b. Signature and title of certified	4	n (m:)).	,	29c. Licens			I	Date signed	' / '	•
			30. Name and address of person	who completed cause of	de th (Item 23a)	(Type, Print)	N65.	DOIVE.	TANE	yTo	WN.	mi	21787
	Sta Registr		30. Name and address of person Wm. R. LIN 31. Date filed (Month, Day, Year)	3 2009 32. Régis	trar's Signature	Span	lad					. , •	~,0.

DHMH 17 Rev 1/2001